The characteristics of inpatient self harm, and the perceptions of nursing staff

James, Karen Anne

Awarding institution:
King's College London

The characteristics of inpatient self harm, and the perceptions of nursing staff

Karen James

Thesis submitted in fulfilment of the requirements of Doctor of Philosophy

The Institute of Psychiatry, Kings College London

June 2015

Abstract

Background: Self harm is an increasingly common behaviour, associated with poor mental health, and an increased risk of death by suicide and other causes. It is one of the principle reasons for admission to inpatient psychiatric services, however very little is known about self harm on wards.

Aims: This thesis set out to address a number of gaps in the literature identified following a systematic review of studies of inpatient self harm. Main aims were to describe the characteristics of self harming behaviour within a national sample of services, and to investigate perceptions of self harm and views of harm minimisation practices amongst inpatient nursing staff.

Methods: Aims were addressed in two studies using a mixed methods approach. Study 1 investigated the characteristics of self harming behaviour within inpatient mental health services across the UK, through a cross-sectional documentary analysis of incident reports. Study 2 was a sequential explanatory study of nursing staff attitudes towards self harm, composed of two phases; Phase I measured staff attitudes and their relationship to staff characteristics, using the Self Harm Antipathy Scale, and Phase II was a qualitative interview study of staff understandings of self harm.

Results: Inpatient self harm was more frequent within acute vs forensic services, largely took place in the private areas of the ward, during the evening hours, and constituted a wide range of behaviours of which cutting was the most common. Inpatient nursing staff generally demonstrated positive attitudes towards self harm, however being a healthcare assistant, or from a non-white ethnic group were associated with more negative attitudes, as were lower SF-36 scores. Staff differentiated between acts of 'self harm' and 'attempted suicide' using a wide range of criteria which differed between individual participants. Views of harm minimisation practices were mixed.

Conclusions: Specialist training in mental health would be beneficial to all practitioners working with people who self harm, and should particularly focus on the interpersonal reasons for self harm**.** Amongst culturally diverse teams of staff there are likely to be multiple understandings of self harm, and those from high religiosity minority ethnic backgrounds may be less accepting of the behaviour**.** Use of the term 'attempted suicide' is problematic and should be avoided. A harm minimisation approach, whilst potentially beneficial to service users, will present significant challenges to some nursing staff.

To my parents, Iain and Helen James.

For first, answering all my questions. Then later, inspiring me to keep asking more.

Acknowledgements

Firstly, thank you to all the nursing staff who participated in this study, for giving up their valuable time, and for sharing their knowledge and experiences with me.

I would especially like to thank Professor Len Bowers and Dr Duncan Stewart for all I have learnt during my time with them, for their support, guidance and enthusiasm, and for challenging me to be a better researcher.

Special thanks also go to Professor Alan Simpson and City University's Service User Group Advising on Research (SUGAR), and in particular Isaac Samuels, whose feedback and advice greatly shaped the direction of thesis.

To the Safewards trial Research Assistants, for their help with data collection and for transcribing my interviews, especially Glorianne Spiteri, Sophie Marsh-Picksley and Sarah Fife who provided valuable comments on Chapter 6.

Thanks also go to colleagues and friends who have given me support and advice along the way, including Geoff Brennan, Karen Wright, Alan Quirk, Morgan Ostertag, Deborah Robson, Caroline Fonjock, Laoise Renwick, Mary Lavelle and Michelle Richardson.

To my friends, my parents, my brothers and the O'Connors, who mostly knew very little of this thesis, but nevertheless offered support and encouragement throughout my studies, and reminded me that 'I can do it!'

And last but never least, Keith O'Connor, who, I have discovered, has boundless patience, strength, words of encouragement and a belief in me which I will never forget, and will always be grateful for- *ní raibh mé abalta é a dheanamh gan tusa.*

CONTENTS

LIST OF TABLES

LIST OF FIGURES

1. Introduction

1.1 Structure of the thesis

This thesis comprises seven chapters: Chapter 1 outlines the background to the study. Chapter 2 presents a systematic review of studies of inpatient self harm, and establishes a need for further research in the areas addressed by this thesis. Chapter 3 provides a detailed description and critical review of the study design and methodology. Chapters 4, 5 and 6 outline the findings of Study 1, and Study 2 Phase I and II respectively. In Chapter 7 these findings are discussed in relation to the current literature, followed by a reflection on the strengths and limitations of the data, and recommendations for nursing practice, education and further research.

1.2 Background to the study

Self harm is an increasingly common behaviour (Perry, Corcoran, Fitzgerald, Keely, Reulbach, & Arensman, 2012) , associated with poor mental health (Haw, Hawton, Houston, & Townsend, 2001; Meltzer et al., 2002), and an increased risk of death by suicide and other causes (Bergen et al., 2012; Hawton, Linsell, Adeniji, Sariaslan, & Fazel, 2014). Population based surveys estimate that around 4% of adults (Briere & Gil, 1998; Klonsky, Oltmanns, & Turkheimer, 2003) and 10% of adolescents (Hawton, Rodham, Evans, & Weatherall, 2002; Moran et al., 2012) have engaged in self harm. 'Self harm' encompasses a wide range of behaviours; the most common method within the general population is cutting, although self-poisoning and self battery are also frequently used (Hawton et al., 2002; Moran et al., 2012). Other methods include strangulation, burning and insertion of foreign objects into the body (Briere & Gil, 1998; Klonsky, 2011). There is no single commonly accepted definition of the term 'self harm' (Silverman, Berman, Sanddal, O'Carroll, & Joiner, 2007), and an on-going debate in the literature about whether, or not, it should include acts of attempted suicide (De Leo, 2006; Muehlenkamp, 2005; O'Carroll et al., 1996). Recent research, however, suggests that non suicidal and suicidal self harm are dimensional variations of a single construct (Orlando, Broman-Fulks, Whitlock, Curtin, & Michael, 2015). In the UK 'self harm' is most often used to describe any act of intentional self-poisoning or self injury, irrespective of the extent of suicidal intent (National Institute for Health and Care Excellence, 2011). The US however, use the term 'non suicidal self injury', which is defined as 'deliberate damage to body tissue without suicidal intent' (Nock & Prinstein, 2004).

Studies investigating risk factors for self harm make up a large part of the research literature, but have had few conclusive findings. Many, but not all studies, report a higher prevalence amongst women (Fliege, Lee, Grimm, & Klapp, 2009; Klonsky et al., 2003; Schmidtke et al., 1996), with gender differences most pronounced during early adolescence (Hawton, Hall, et al., 2003). Young people are thought to be at greater risk (Klonsky, 2011), and there is an association between childhood trauma and self harm (Fliege et al., 2009; Johnson et al., 2002), particularly childhood sexual abuse (Klonsky & Moyer, 2008). Around 90% of those who self harm meet the criteria for diagnosis of a psychiatric disorder (Haw et al., 2001; Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006), most commonly depression and anxiety (Klonsky et al., 2003). Self harm is also strongly linked to borderline personality disorder (Andover, Pepper, Ryabchenko, Orrico, & Gibb, 2005; Klonsky et al., 2003) as it features as a criteria for this diagnosis (American Psychiatric Association, 2013). Alcohol and substance misuse is common amongst people who self harm (Haw et al., 2001; Langbehn & Pfohl, 1993), as is suicidal ideation (Nock et al., 2006). Self harm is one of the few established risk factors for suicide (Cooper et al., 2005; Hawton et al., 2015), and reduction of self harm has formed an important part of anti-suicide strategies within the UK (Department of Health, 2002)

The motivations for self harm are varied and complex, and the behaviour can often hold a number of different meanings for one person (Klonsky, 2009). It is most commonly used to alleviate emotional distress (Klonsky, 2007), for example, some people find the physical pain caused by self harm helps to distract them from their emotional pain (Babiker & Arnold, 1997). The moderating effect of pain on emotional affect has been illustrated in laboratory studies where administration of a painful stimulus results in a reduction in negative emotions (Haines, Williams, Brain, & Wilson, 1995), and more recently, FMRI studies have illuminated the possible neural correlates of this process (Niedtfeld et al., 2010). For around half of people who cut themselves, seeing blood is important. Blood can symbolise the release of unwanted feelings from the body (Glenn & Klonsky, 2010), or can help to relieve periods of depersonalization, where people enter a dream-like state and feel disconnected from their physical selves. In these cases, seeing blood can help people become fully conscious again (Schoppmann, Schröck, Schnepp, & Büscher, 2007). Another common function of self harm is ‘self punishment’, endorsed by between 10% (Herpertz, 1995) and 83% (Briere & Gil, 1998) of people completing self-report measures. This can be a response to extreme feelings of low self worth, or a re-enactment of past abuse (Babiker & Arnold, 1997). For survivors of abuse, self harm can also be a way of coping with feelings of being ‘bad’ or contaminated inside by allowing people to remove this part of themselves (Harris, 2000).

Self harm can also be used to communicate with others, or to change their behaviour (Nock, 2008). A survey of young people in seven countries across Europe revealed that for 67%, self harm was intended to have an impact on others, for example to get some attention, or to frighten someone (Scoliers et al., 2009). For some people the scars of self harm can be a way of communicating their distress when they feel unable to express this pain in words (Reece, 2005), or believe that they will not be heard (Babiker & Arnold, 1997). There is evidence that different methods of self harm may serve different functions; a survey of 144 women admitted to a treatment unit for eating disorders found that bruising was primarily used as a form of self-punishment, whilst other methods of self harm such as cutting were used to regulate emotions (Claes, Klonsky, Muehlenkamp, Kuppens, & Vandereycken, 2010). In a larger survey of over 6,000 adolescents, participants who took overdoses were more likely to have wanted to find out if someone loved them compared to those who cut themselves (Rodham, Hawton, & Evans, 2004).

People who self harm consistently report negative experiences of care across all clinical settings (Taylor, Hawton, Fortune, & Kapur, 2009), and in particular, a lack of understanding of self harm, and a lack of sympathy amongst clinical staff (Harris, 2000; Pembroke, 1994; Reece, 2005). These issues have been identified as significant barriers to the provision good quality of care in a number of research reports (Brophy & Holmstrom, 2006; Royal College of Psychiatrists, 2010) and clinical guidance (National Institute for Health and Care Excellence, 2011). Studies using self-report Likert measures, have found that staff have a mixture of both positive and negative feelings towards those who self harm (Conlon & O'Tuathail, 2012; Gibb, Beautrais, & Surgenor, 2010; Patterson, Whittington, & Bogg, 2007a). Staff characteristics associated with positive attitude scores include training in self harm and registration as a mental health vs general health practitioner (Commons-Treloar & Lewis, 2008; Dickinson & Hurley, 2012; Dickinson, Wright, & Harrison, 2009; Patterson et al., 2007a; Patterson, Whittington, & Bogg, 2007b). However, findings regarding the influence of other variables such as gender, age and clinical experience are mixed (Conlon & O'Tuathail, 2012; Dickinson & Hurley, 2012; Dickinson et al., 2009; Gibb et al., 2010; Huband & Tantam, 2000; Patterson et al., 2007a, 2007b). Qualitative studies exploring the experiences of practitioners have revealed some complex issues. Descriptions of people who self harm as being attention seeking and manipulative are common (McHale & Felton, 2010; Sandy, 2013; Smith, 2002), and staff often report a lack of confidence in supporting people who self harm, and difficulties understanding their behaviour (Dickinson et al., 2009; Friedman et al., 2006; McAllister, Creedy, Moyle, & Farrugia, 2002). It appears that working with people who self harm can evoke emotions such as

anger, fear, frustration, and feelings of powerlessness (Hadfield, Brown, Pembroke, & Hayward, 2009; Smith, 2002; Wilstrand, Lindgren, Gilje, & Olofsson, 2007).

In the UK, most support for people who self harm is provided by the National Health Service (NHS), which includes General Practitioners (GPs), Emergency Departments (EDs), and community and inpatient mental health services. It is estimated that around 200,000 people present to emergency departments each year following self harm (Hawton et al., 2007; National institute for Health and Care Excellence, 2011), and just over half will be admitted to a general ward for treatment (Cooper et al., 2015). The quality of support provided by general hospitals (i.e. numbers receiving psychosocial assessment, hospital admission and referral to specialist services) is variable, and is not associated with rates of repetition of self harm (Cooper et al., 2015). Despite a strong association with poor mental health, around three quarters of people attending EDs following self harm will not be in contact with specialist mental health services (Hawton, Fagg, Simkin, Bale, & Bond, 1997), and this proportion is even smaller within the general population. For example, a recent UK study of adolescents who had self harmed found just 5% had been in contact with specialist services in the past 6 months (Sayal, Yates, Spears, & Stallard, 2014). UK clinical guidance states that rather than focussing on the self harming behaviour, specialist interventions for self harm should seek to support people with any underlying problems which may be causing the behaviour, such as depression or past trauma (National institute for Health and Care Excellence, 2011).

There is currently no evidence for the effectiveness for pharmacological interventions for self harm, but some evidence that a range of psychological interventions can help to reduce repetition, and improve outcomes such as depression and hopelessness. These include problem solving and dialectical and cognitive behavioural therapies (Hawton et al., 2015; National institute for Health and Care Excellence, 2011). However these data are limited due to small samples and variability in populations and treatment modalities, which make it difficult to compare across studies (Hawton et al., 2015; National institute for Health and Care Excellence, 2011). Another approach is harm minimisation, which has previously been successful in supporting people with substance misuse problems (Riley et al., 1999). Harm minimisation for self harm means "*accepting the need to self-harm as a valid method of survival until survival is possible by other means…and is about facing the reality of maximising safety in the event of self-harm"* (Pembroke, 2009, p. 6). Harm minimisation practices can include advising people how to self harm safely, how to clean their wounds, and supplying them with safer means to self harm, such as clean blades. Just a handful of studies have investigated these practices to date and there is very little evidence for their effectiveness. However, harm minimisation is advocated by some service users, who find that being prevented from

self harming causes them more distress (Duperouzel & Fish, 2008; Pembroke, 1994), and has been adopted by some specialist services (Birch, Cole, Hunt, Edwards, & Reaney, 2011). The approach was reviewed by recent NICE guidance, which recommended '*tentative approaches to harm reduction for some people who self-harm*' in the community, but made no recommendations about the use, or role, of harm minimisation within inpatient services (National institute for Health and Care Excellence, 2011, p. 259).

Self harm is one of the most common reasons for admission to psychiatric inpatient services (Bowers, 2005; Way & Banks, 2001), and inpatient admissions make up 66% of the health and social care costs associated with self harm (Sinclair, Gray, Rivero-Arias, Saunders, & Hawton, 2011). Inpatient staff provide 24 hour care for people with the most severe and complex mental health needs, which involves the management of challenging behaviours such as physical and verbal aggression, absconding, substance misuse and suicide as well as self harm (Bowers, Simpson, & Alexander, 2003). In addition, inpatient services face many challenges due to systemic problems, such as high bed occupancy, understaffing and large amounts of paperwork and administrative duties (Braithwaite, 2006; Jenkins & Elliott, 2004; Royal College of Psychiatrists, 2011). Over the past decade inpatient care has been subject to a number of critical reports which highlight a lack of therapeutic interaction between staff and service users, a lack of person centred and recovery focussed care, deficits in leadership and clinical skills, and a climate of fear and focus on risk management (Braithwaite, 2006; Mind, 2004). Despite these challenges, and the important role inpatient wards play in supporting people who self harm (Bowers, 2005), there has been very little research in this area, and to date, no systematic reviews of evidence regarding inpatient self harm.

1.2.1 Concluding comments

There has been a large body of research into self harm within the community, however far less is known about self harm on psychiatric wards: What factors are associated with self harm amongst this population? What are the characteristics of inpatient self harm? How are these behaviours perceived by nursing staff? What approaches do nursing teams use to support people who self harm? What sense does any distinction between self-harm and attempted suicide have in this setting, and with what repercussions? The following chapter presents a systematic review of self harm which aimed to summarise current evidence in this field and identify areas for future research, some of which are addressed in this thesis.

2. Systematic review of research into inpatient self harm

This chapter describes the findings of a systematic review of research into inpatient self harm. The aim of this review was to summarise current evidence in the field and identify areas for future research. Because of the large degree of heterogeneity between studies it was not possible to conduct a meta analyses using quantitative data, and so this chapter presents a narrative analysis of findings drawn from both qualitative and quantitative studies together. It first gives an overview of the review methodology, followed by the design and characteristics of the studies included. The results are then organised according to seven themes identified in the literature, as follows;

1. Incidence
2. Correlates
3. Characteristics
4. The reasons for, or antecedents to, self harm
5. Interventions
6. Organisational issues
7. Staff perceptions
8. Costs

1.3 Methodology

Searches of the main electronic databases (PsycInfo, Cochrane, Medline, EMBASE Psychiatry, CINAHL and the British Nursing Index) were conducted using the keywords: attempted suicide, automutilation, factitious wounds, self destructive behaviour, self harm/self-harm, self-inflicted injuries, self-injurious behaviour, self inflicted wounds, self mutilation and parasuicide. Following this initial search, the numbers of identified references were reduced by searching within the findings for any of the following terms: (inpatient* OR hospital* OR ward*) AND (psychiatr* OR mental*). As the literature accumulated, further references were obtained by following up citations. The results from each relevant study were entered into a structured data extraction tool for analysis.

Inclusion criteria were all empirical studies of self harm and attempted suicide within adult psychiatric inpatient services (acute, forensic, rehabilitation units, and psychiatric intensive care unit settings), published in English, between the years 1960 – 2014 (October).

Exclusion criteria were studies conducted within older adult, adolescent, or children's mental health services, and studies including only samples of service users who had a history of self harm, but who did not self harm during an inpatient stay.

1.4 Study design and characteristics

Electronic searches produced a total of 1, 286 studies of which 108 met the inclusion criteria (see Appendix A). Self harm and attempted suicide were the main focus of just 56 studies. The remainder of the literature included some data about self harm, however was primarily concerned with aggression, or other behaviours within inpatient psychiatry. Most research was conducted within acute services (n=74), followed by forensic (n=22), psychiatric intensive care (n=2), and acute assessment (n=1) services. Eight studies collected data from several different settings, and the location of one study was not specified. Thirteen different countries were represented in the literature, however most data were from the UK and USA (Table 1).

Most studies (n=41) investigated the incidence, and characteristics of self harming behaviour, or the characteristics of people who self harmed. These data were largely collected retrospectively from clinical notes or official incident reports, although a minority (n= 9) of studies collected prospective data. Twenty one studies reported data regarding the impact of interventions on rates of self harm, although under half focused specifically on interventions for self harm. Most intervention studies used a natural before and after design (n = 10), two with controls. There were no Randomised Controlled Trials. Quantitative studies were largely descriptive, and those that did use inferential statistics were mostly restricted to univariate analyses. Very few studies collected qualitative data; six were clinical case studies, and ten collected interview data regarding staff and service user experiences of self harm. Just two studies used mixed methods, both adopted a case control design which also included a qualitative case study (Coons & Milstein, 1990) or interview data (Rosenthal, Rinzler, Wallsh, & Klausner, 1972) exploring the reasons for self harm.

Table 1. Number of studies reviewed, by country

Country	*n*
UK	48
USA	26
Australia	6
Germany	5
Republic of Ireland	4
Canada	3
Greece	3
Norway	3
Netherlands	2
Sweden	1
Italy	1
Mexico	1
Switzerland	1
New Zealand	1
Denmark	1
UK, Greece and Italy	1

1.5 The definition of self harm

Studies used a wide range of terms to describe self harm, including auto mutilation, auto aggression, aggression against self, self mutilation, self harm, deliberate self harm, self injury, parasuicide, attempted suicide and suicidal behaviour. These terms were used to describe a variety of behaviours which could include any act resulting in harm to self, acts restricted to tissue damage only, or a specific method of self harm such as cutting. Just under half of all studies (n=51) offered no definition of these terms. Twenty eight studies defined self harm as an act carried out without suicidal intent, however only seven specified how this intent was determined. These used a variety of criteria, including the lethality of the attempt, expression of suicidal intent, clinician classification, or other rating scales such as the Overt Aggression Scale. In this review studies of attempted suicide are examined separately where possible.

1.6 Incidence of self harm

Forty three studies reported the incidence of self harm or attempted suicide. Rates were standardised to allow for comparisons. There was substantial variation in the rates of self harm and attempted suicide between studies (Table 2), although rates of self harm tended to be higher on forensic wards (Table 3).

Table 2 Rates of self harm and attempted suicide

	Self harm				Attempted suicide			
Rate	*n (studies)*	*Mean*	*Min*	*Max*	*n (studies)*	*Mean*	*Min*	*Max*
Percentage of service users who self harmed/attempted suicide†	25	17.4	0.67	68.8	5	1.4	0.32	2.94
Patient rate/100 admissions/month‡	14	20.0	0.67	68.8	3	1.2	0.32	2.94
Event rate/100 admissions/month§	15	280.8	0.35	1868.6	3	3.2	0.53	8.25

†. Number of service users who self harmed/attempted suicide, as a percentage of the total number of service users in the study
‡. Number of service users who self harmed/attempted suicide per 100 admissions per month
§. Number of incidents per 100 admissions per month

Between 26% (Nijman & Campo, 2002) and 65% (O'Shea, Picchioni, Mason, Sugarman, & Dickens, 2014) of those who self harmed did so on more than one occasion, although differences in the length of study period makes it difficult to draw comparisons. The maximum number of incidents per service user ranged from one (Daffern & Howells, 2007; Jackson, 2000) to 17 per month (O'Shea et al., 2014). One study examined at the timing of repetitive self harm amongst 522 people during the first two weeks of their admission, and reported a mean interval of 2.2 days between incidents (Stewart, Ross, Watson, James, & Bowers, 2011). This was the only study to report data about repetitions of attempted suicide, and found that 30% (n=7) did so more than once, with a maximum number of seven attempts, and a mean of 1.7 attempts per service user. The mean interval between repeated attempted suicides was 2.1 days.

Table 3. Combined rates of self harm by type of ward

Rate	Acute				Forensic			
	n (studies)	*Mean*	*Min*	*Max*	*n (studies)*	*Mean*	*Min*	*Max*
Percentage of service users who self harmed†	16	7.0	0.67	20.51	7	42.9	17.26	68.75
Patient rate/100 admissions/month‡	7	3.9	0.67	7.75	5	46.2	17.26	68.75
Event rate/100 admissions/month§	5	2.8	0.35	5.38	8	522.6	18.23	1868.6

†. Number of service users who self harmed, as a percentage of the total number of service users in the study
‡. Number of service users who self harm per 100 admissions per month
§. Number of incidents per 100 admissions per month

1.7 Correlates of self harm

Studies investigating the correlates of self harm made up a large proportion of the literature, and were mostly concerned with identifying predictors of inpatient self harm which could be used to assess risk. These studies typically adopted a cross-sectional retrospective design, where the demographic and clinical characteristics of service users were obtained from clinical records. Twenty eight were case control studies, the majority of which used the population of service users who did not self harm during the study period as a control group, or a random selection of these people. Just two studies constructed a control group matched on demographic, or clinical characteristics (Gardner & Gardner, 1975; Sweeny & Zamecnik, 1981). There were no longitudinal studies, and most studies were conducted within single hospitals. Few (n=4) examined self harm across multiple services, or even multiple hospitals within a single service (Bowers et al., 2002; Bowers et al., 2005; O'Shea et al., 2014; Pirkis, Burgess, & Jolley, 1999; Stewart et al., 2011). The most robust evidence for the correlates of self harm was from the very limited number of studies which included multivariate analyses (Bowers, Allan, Simpson, Nijman, & Warren, 2007; Bowers, Whittington, et al., 2008; Neuner, Schmid, Wolfersdorf, & Spiebl, 2008; Spiebl, Hubner-Liebermann, & Cording, 2002; Stewart et al., 2011)

Somewhat surprisingly, most case control studies found no significant association between gender and self harm (Beer, Muthukumaraswamy, Khan, & Musabbir, 2010; Bowers et al., 2003; Callias & Carpenter, 1994; Karson & Bigelow, 1987; Myers & Dunner, 1984), although there were significantly higher rates of attempted suicide amongst women (Lee, Villar, Juthani, & Bluestone, 1989; Neuner et al., 2008).

Stewart et al. (2011), found that within acute services, the odds of women attempting suicide were over four times greater than those for men, and although univariate tests found that women were more likely to self harm, gender was not a significant predictor in the multivariate analysis.

There was a consensus that self harm was most prevalent amongst younger age groups. Five studies, including a very large study of 2,486 admissions found that people who self harmed were significantly more likely to be younger than those who did not (Bowers et al., 2003; Callias & Carpenter, 1994; Hillbrand, 1995; Jackson, 2000; Low, Terry, Duggan, MacLeod, & Power, 1997; Stewart et al., 2011), whilst two found no association with age (Beer et al., 2010; Modestin & Kamm, 1990). Younger people were also at a greater risk of attempted suicide (Neuner et al., 2008; Pirkis et al., 1999; Stewart et al., 2011), and this effect was strongest for younger females (Pirkis et al., 1999).

Most studies reported no relationship between ethnicity and self harm (Bowers et al., 2003; Hillbrand, Young, & Krystal, 1996; Myers & Dunner, 1984; O'Shea et al., 2014). Although a large multivariate study found the proportion of service users from a Caribbean ethnic background was associated with increased rates of self harm (Bowers, Whittington, et al., 2008), whilst Beer et al. (2010) and Brown and Bass (2004) found significantly higher rates amongst people of white ethnic origin. One international study found people from an ethnic minority background were significantly more likely to self harm in Greece, however not in Italy and the UK (Bowers et al., 2005).

Findings regarding psychiatric diagnosis were inconsistent, and because studies used different diagnostic systems, and most only provided the primary diagnosis, it was difficult to reach reliable conclusions. Self harm is a criterion for a diagnosis of personality disorder, and although there was some evidence that people with this diagnosis were significantly more likely to self harm (Hillbrand, Krystal, Sharpe, & Foster, 1994; Low et al., 1997; Myers & Dunner, 1984), this finding was far from uniform in the literature (Beer et al., 2010; Bowers et al., 2003; Callias & Carpenter, 1994; Gardner & Gardner, 1975; Hillbrand, 1995; Modestin & Kamm, 1990). There was agreement between two multivariate studies of attempted suicide, that people with a diagnosis of schizophrenia, personality disorder, and either affective disorder (Spiebl et al., 2002), or depression (Neuner et al., 2008) were an increased risk.

People who self harmed during their admission were significantly more likely to have a history of self harm (Beer et al., 2010; Stewart et al., 2011; Sweeny & Zamecnik, 1981). Similarly, a previous suicide attempt was a significant predictor of an attempt during hospitalisation (Neuner et al., 2008). The proportions of those with a history of self harm ranged from 44% (Beer et al., 2010) to 89% (Rosenthal et al., 1972) of all people who self harmed during an admission, suggesting that a number of people who

self harm within inpatient services do so for the first time once they have been admitted to the ward.

There was some evidence for the impact of social factors on self harm, however data was limited due to small numbers of studies in this area. There was an increased prevalence on wards with lower levels of deprivation (Bowers, Whittington, et al., 2008), people who self harmed were more likely to be living in rural areas (Modestin & Kamm, 1990) and were more likely to have a history of physical and sexual abuse, and childhood conduct problems (Beer et al., 2010). Studies found no relationship between self harm or attempted suicide and marital status (Stewart et al., 2011). People who attempted suicide were significantly more likely to be living with their parents, but there was no relationship with high school qualification (Spiebl et al., 2002).

A number of studies were interested in the relationship between self harm and aggression, and most evidence indicated that these behaviours are related. Studies which examined this at an individual level found that people who self harmed were significantly more likely to be aggressive during an admission (Hillbrand, 1992; Hillbrand et al., 1994; O'Shea et al., 2014). Similarly Ehmann et al. (2001) found a significant correlation between rates of self harm, physical aggression and aggression towards objects within a forensic service. One study looked at rates of self harm and aggression across three European countries, and found no statistically significant association with aggression (Bowers et al., 2005). The most robust evidence, however, was from a number of large multivariate studies within acute services which found that that aggression towards objects and others was significantly associated with increased rates of self harm across wards in England (Bowers et al., 2007; Bowers et al., 2008).

Few studies examined the relationships between self harm and attempted suicide; Hillbrand et al. (1994) noted that 89% of male forensic inpatients who self harmed had a history of attempted suicide, whilst Stewart et al. (2011), reported a strong statistical association between self harm and attempted suicide during the first two weeks of an admission.

Five studies examined the effectiveness of risk assessment tools in predicting self harm. These tools were all originally developed to assess risk of aggression, and measured a range of factors such as history, current metal state, level of functioning, and external factors such as level of social support, and life goals. Although all studies found significant differences in risk scores between those who self harmed, and those who did not, most reported low effect sizes (e.g. an AUC equal to, or less than 0.7) and so poor predictive validity (for the Historical-Clinical-Risk Management- 20 (HCR-20), the Dynamic Appraisal of Situational Aggression (DASA), the Short-Term Assessment of Risk and Treatability (START), and the Structured Assessment of Protective factors for

violence risk (SAPROF) (Abidin et al., 2013; Daffern & Howells, 2007; O'Shea et al., 2014). Abidin et al. (2013), found that measures of treatment programme completion (DUNDRUM-3) and recovery (DUNDRM-4) were successful in predicting self harm within a forensic hospital over a six month period. The most reliable predictors however, were the service user's own assessments of their risk. Roaldset (2010), administered the Self Report Risk Scale to 489 people admitted to an acute hospital over the course of one year and found good accuracy for prediction of self harm and suicidal behaviour during their admission (e.g. AUCs of 0.82 and 0.92 respectively).

In summary, current data regarding the correlates of inpatient self harm is limited, however indicates a higher incidnece amongst younger age groups and those with a history of self harm. There is very little evidence for an association with gender, or psychiatric diagnosis. Smaller studies employing univariate analyses also found no association with ethnicity, however, a more robust, large multivariate, study did, suggesting that there may be a link. More research of this design is required to provide conclusive findings. In general, studies indicate a higher risk of aggression amongst people who self harm during an admission, compared to those who do not. There was very little research into the impact of social factors on self harm, particularly negative life events such as abuse, bereavement and adverse childhood experiences, shown to be associated with self harm in general population samples (O'Connor, Rasmussen, & Hawton, 2009).

1.8 Characteristics of self harm

As with correlates of self harm, most research examining the characteristics of self harm was conducted using a cross sectional retrospective analysis of clinical notes. There were no national data, or data from several different services. Studies identified various methods of inpatient self harm (Table 4). People most commonly self harmed by cutting, although head banging, punching or kicking objects and strangulation were also frequently used, whilst inserting objects into the body, re-opening old wounds, burning and self poisoning were less common (Beasley, 1999; Beer et al., 2010; Burrow, 1992; Callias & Carpenter, 1994; Foster, Bowers, & Nijman, 2007; Jackson, 2000; Mannion, 2009; Swinton, Hopkins, & Swinton, 1998). 'Other' methods of self harm included binging/vomiting, biting, burning, electrocution, enucleation, hunger strike and drowning.

Rates of self harm and attempted suicide were consistently higher in the private areas of the ward (Beasley, 1999; Bowers, Dack, Gul, Thomas, & James, 2011; Low et al., 1997), and during the evening hours (Myers & Dunner, 1984; Stewart et al., 2011; Swinton et al., 1998). There were no significant differences in rates of self harm reported for days of the week, or months of the year (Beasley, 1999). Bowers et al. (2011) found

no significant differences in the number of suicide attempts occurring on days of the week, but did report an unequal distribution of suicide attempts across months of a year. In a rare prospective study, Nijman and Campo (2002) collected data about timing and location of self harm on a locked admission ward over a period of 3.5 years and asked staff to mark the location of each incident on a map of the ward. They found that most incidents took place in bedrooms (66%), compared to day rooms (7%), hallways (7%), dining rooms (4%) and the staff office (3%). A significantly higher proportion of incidents occurred between 6pm and 12pm, reaching a peak between 8pm and 9pm.

Table 4. Prevalence of methods of self harm

Method	*% of total incidents (weighted average)*	*max*	*min*	*n (studies)*
Cutting	33.7	55	10	8
Head banging/punching/kicking	22.5	42	13	7
Strangulation/suffocation/drowning	17.1	24	13	5
Insertion of foreign objects into body	9.3	12	2	5
Re-opening/interfering with old wounds	8.6	13	3	3
Burning	6.5	8	2	4
Self poisoning	3.3	9	1	4
Other	5.6	62	2	6

There was very little information about the objects used to self harm, and studies which did report this information lacked detail. For example, Foster et al. (2007) reported only that that glassware (19%) was commonly used, followed by knives (13%), other weapons (13%), other objects (26%), a hand (3%), a foot (3%) and other body parts (13%), whilst data from Mannion (2009) was limited to walls/doors (18%), a pen (11%) or a staple (11%).

Studies typically used the level of intervention required to treat any injuries sustained as an indicator of the severity of self harm. According to this definition, incidents were on the whole, low severity; between 41% (Mannion, 2009) and 77% (Foster et al., 2007) required no treatment, between 8% (Low et al., 1997) and 12% (Burrow, 1992) required an invasive medical intervention and 7% (Beasley, 1999) to 11% (Mannion, 2009) required hospitalisation. In a large study of self harm on 136 acute wards, Bowers, Whittington, et al. (2008), collected information about the lethality of self harm over a 6 month period using the lethality of suicide attempt rating scale (Smith, Conroy, & Ehler, 1984). Of those shifts where there had been an incident of self harm,

85% were low lethality, with scores of 0 or 1 (meaning death was impossible or very highly improbable). Contrastingly, a national UK study of incident reports of attempted suicide, found a mean lethality score of 2.1 for 'low severity attempts' and 8.0 for 'high severity' attempts (Bowers et al., 2011)

In conclusion, evidence regarding the characteristics of self harm is currently restricted to single hospital studies. These findings suggest inpatient self harm constitutes a wide range of behaviours, of which cutting is the most common. It is most frequent during the evening hours, and in the private areas of the ward. Very little is known about the objects used to self harm, and although a number of studies recorded the intervention required to treat injury, very few examined the potential lethality (i.e. risk to life) of the act.

1.9 Antecedents to, or reasons for, self harm

Surprisingly few studies reported data about the reasons for self harm. Those that did were mostly case studies of just one or two service users, conducted in the 1960s. No studies examined statistical relationships between self harm and its precursors.

In case studies, reasons for self harm included being placed in seclusion (Coons & Milstein, 1990), staff denial of request, a noisy and disruptive ward (Bisconer, Green, Mallon-Czajka, & Johnson, 2006), relationship problems (Grunebaum & Klerman, 1967; Rinzler & Shapiro, 1968), a build-up of 'inner tension' (Grunebaum & Klerman, 1967; Pao, 1969), and feelings of emptiness, or depersonalisation (Rinzler & Shapiro, 1968). A number of descriptive studies reported the events preceding an incident of self harm, however there were substantial differences in the ways in which these events were categorised between studies, making comparisons difficult. A prospective study, which also examined antecedents to aggression, revealed that staff often struggled to identify the reasons for self harm (Nijman & Campo, 2002). Staff reported "no understandable provocation" in 47% of incidents, and even within the same patients, a significantly higher proportion of the reasons for self harm were unclear to staff compared to the reasons for outwardly directed aggression (47% versus 35%). In this paper just two possible explanations for self harm were reported; denial of a request (17%) and a reaction to other patients behaviour (6%). In a more comprehensive study, Mannion (2009) found that 'conflict' on the ward was the most common antecedent to 309 incidents of self harm within a forensic service. 'Conflict' described a range of situations which included ward issues (25%), staff denial of a request (8%), a request being made (1%), seclusion (7%), previous self harm (1%) and refusal of medication/support (1%). The study reported that 'internal mood state', such as anger or hopelessness featured in 30% of incidents, followed by personal problems such as bereavement (7%), anxiety concerning legal

matters (2%) or things discussed during therapy (2%), and previously expressed self harm ideation (1%). Contrastingly, a similar study (Beasley, 1999), found that most incidents were reported to have occurred in response to patients internal experiences (64%; psychotic experience, low mood, intrusive thoughts) rather than external factors (18%; anniversaries of traumatic life events, seasonal events, issues relating to peer group, residential location and care). Stewart et al. (2011), examined conflict events recorded before incidents of self harm and attempted suicide for a sample of 522 acute inpatients, and found differences in the events connected to these behaviours; verbal aggression, and aggression to objects were the most comment antecedents to incidents of self harm, whilst absconding was most common before an attempted suicide.

Just three studies included the perspectives of people with lived experience of self harm. All were interview studies within acute services, and with women only. Gardner and Gardner (1975) conducted structured interviews with 22 women, and found 86% said they self harmed to relieve tension and 41% because they wanted to end their life. Other reasons were: feeling angry with others (31%), to get attention (23%), because they were angry with themselves (18%), or because they were sexually frustrated (5%). Rosenthal et al. (1972), spoke to participants immediately after they had cut themselves and found that feelings of depersonalization featured in 23 out of 25 incidents. These women described feeling numb, unreal and empty before they cut, or said they had no feelings, or felt empty inside. Self harm helped to stop these feelings, and for many, seeing blood played an important role in this. The authors noted that these women often self harmed when they were disappointed with their care, or when discharge was being planned, providing further evidence for the impact of the ward environment on self harm. This was also noted in a study by Weber (2002), who interviewed nine women about their experiences of self harm, and found triggers included a noisy ward, or feeling upset or angry with someone. These women felt it was difficult to predict when they were about to self harm because it could be triggered very quickly. Other reasons for self harm included feeling dirty, or lonely. In another qualitative study, Breeze and Repper (1998), explored the experiences of 6 people who were identified by nurses as being 'difficult patients', and found they sometimes used self harm as a way to regain control in situations when they felt that control was being taken away from them. Control was also identified as a reason for self harm in a study of 11 nurse's experiences of suicidal patients (Carlen & Bengtsson, 2007). Nurses saw people who were suicidal as being out of control, and believed that suicidal thoughts were a comfort to these service users, as they saw suicide as a way of exerting control over their lives. Nurses also mentioned that some people displayed suicidal behaviour before being discharged, and felt this was because they wanted to stay in inpatient care as they lacked support outside of hospital.

In summary, studies investigating the reasons for, or antecedents to self harm were mainly limited to staff accounts of the event, however, there was evidence that staff frequently struggled to understand the reasons for self harm. These studies highlighted a wide range of situations which may lead to inpatient self harm which were generally related to internal experiences (e.g. changes in mood, a build-up of tension, feelings of depersonalisation), life events (e.g. bereavement, upcoming court cases, relationship problems) and, importantly, problems related to the ward environment itself (such as noise, a lack of control, conflict with other service users and conflict with staff).

1.10 Interventions for self harm

A wide range of interventions for self harm were described in the literature, and largely had one of two aims; to prevent people from self harming during an admission (containment strategies), or to address the underlying reasons for self harm, and so help people to stop self harming in the long term (psychosocial interventions). These also included studies of psychosocial interventions which aimed to improve the standard of nursing care on the ward in general, and measured impact on rates of self harm amongst other outcomes.

1.10.1 Containment strategies for self harm

Descriptive studies documenting the containment strategies used by wards are summarised in Table 5. However, because of inconsistencies in the types of containment reported, and because all were single hospital studies, it is difficult to draw firm conclusions about the extent to which these interventions are used across services. Most often nurses responded with ‘verbal de-escalation’ (Beasley, 1999; Foster et al., 2007), which can constitute any supportive form of verbal communication between staff and service user. Manual restraint, and Pro Re Nata (PRN) medication were also frequently used (Beasley, 1999; Foster et al., 2007; Parkes, 2003), whilst special levels of observation, and seclusion were used less frequently (Foster et al., 2007; Low et al., 1997; Parkes, 2003). Other management strategies less prominent in the literature were the removal of means of self harm, instructing service users to remain in their nightclothes, body and bedroom searches, no suicide contracts, moving the person away into a private area (time out), distraction strategies and threatening negative consequences for self-harming behaviour, e.g. not being able to receive visitors (Breeze & Repper, 1998; Foster et al., 2007; Langan & McDonald, 2008; Lindgren, Öster, Åström,

& Graneheim, 2011; O'Donovan, 2007; Sandy & Shaw, 2012; Tobin, Lim, & Falkowshi, 1991).

Table 5. Containment strategies for self harm

Study	Setting	Data collection	*n* (incidents)	Frequency of use (% of total incidents)					
				Verbal de-escalation	Special obs†	Seclusion	PRN/ IM meds‡	Manual restraint	Other
Beasley (1999)	Forensic UK	Retrospective from nursing notes	1165	92%			19%	25%	
Foster (2007)	Acute UK	Prospective	31	49%		3%	26%	19%	84%
Low (1997)	Forensic UK	Retrospective from nursing notes	1607		4%				
Parkes (2003)	Forensic USA	Prospective	216			2%		12%	
Tobin (1991)	Acute UK	Retrospective from nursing notes	27				14%	14%	

†. Special levels of observation (e.g. intermittent checks, or constant observation of an individual by nursing staff)

‡. Pre. Re. Nata or Intra Muscular medication

Worryingly, the only evidence for the impact of these interventions can be drawn from a small number of observational studies, using correlational designs, which assessed statistical relationships between containment and rates of self harm. In a number of large scale studies, Bowers, Whittington, et al. (2008), found the use of intermittent observation within a shift was associated with decreased rates of self harm within that same shift, but that there was no relationship between self harm and use of constant observation. This study also found that having the door locked for more than 3 hours, or for a full shift, was associated with increased rates of self harm. In a later study, the same researchers found that the use of constant observation within one week was associated with higher levels of self harm during that same week, but not reduced levels of self harm in the following week (Stewart, Bowers, & Warburton, 2009). Drew (2001) conducted a retrospective review of clinical records to assess the outcomes of no suicide contracting, a practice in which an individual makes a signed written agreement with a member of staff that they will not attempt to take their own life. This study found people with contracts were more likely to engage in self harm and suicidal behaviour compared to those who did not. Interestingly, the study also found that the higher the level of environmental restriction (degree of staff's control over the service user's movements), the greater the

likelihood of self harm. Finally, one study reported that over half of forensic service users who self harmed did so whilst they were in a seclusion room, suggesting that this is not an effective strategy to reduce self harm (Mannion, 2009).

Qualitative research highlighted staff concerns about the use of containment measures for self harm. A common theme was the use of special observation, which staff felt invaded the service user's personal space, violated their privacy, increased the time they spent thinking about self harm, made them feel uneasy, and gave them too much attention (O'Donovan, 2007; Sandy & Shaw, 2012; Wilstrand et al., 2007). Some staff disputed its effectiveness, recalling incidents where people had continued to self harm whilst being under observation (Sandy & Shaw, 2012) or started self harming within minutes of coming off it (O'Donovan, 2007). However, despite their reservations, staff believed they had no alternative methods of keeping service users safe (O'Donovan, 2007). Similarly, staff felt uncomfortable asking people to remain in their nightclothes; a practice used to prevent people from hiding means to self harm on their person, and restrict their access to items of clothing that could be used as a ligature, but did so because they knew no other way to prevent people from harming themselves (O'Donovan, 2007). A number of qualitative studies reported that, in fact, staff felt it was altogether unrealistic to expect them to stop people from self harming (Sandy & Shaw, 2012; Smith, 2002).

The few studies which sought the views of service users were limited to acute services, all were qualitative, and with the exception of one, were conducted within the UK or Ireland. These found that on the whole, people had a very negative experience of care. Service users reported a lack of understanding of self harm amongst staff, and felt they did not spend enough time trying to understand why they self harmed. They described being made to feel like 'naughty children' when they self harmed, and as if they were a burden to staff (Smith, 2002). In a Swedish observational study of interactions between staff and service users, Lindgren et al. (2011), found most nursing interventions were focussed on stopping self harm, which service users found unhelpful. Staff and service users often had contradictory views of self harm, where staff viewed it as an abnormal behaviour, and so demanded total cessation of self harm, whilst service users saw it as a functional behaviour, which helped to reduce their suffering, and so believed it was unrealistic to expect them to stop self harming completely. Being prevented from self harming meant that people were unable to relieve their feelings of distress, which increased their desire to self harm. In some cases this meant they started self harming in more 'drastic' ways (Smith, 2002). Regarding specific containment measures, service users said that being forced to wear nightclothes made them feel uncomfortable, embarrassed, humiliated, awkward, and more depressed (Langan &

McDonald, 2008). They also reported negative experiences of being placed under observation, which they found restrictive and 'claustrophobic' (Breeze & Repper, 1998), and felt didn't help them (Smith, 2002). Although in one study, staff described someone who preferred to be under observation, which led to conflict with nursing staff when it was stopped (Breeze & Repper, 1998).

Concerns about the containment measures used to prevent self harm have led some wards to adopt a harm minimisation approach. Harm minimisation means that people are not prevented from self harming during an admission, and so negates the use of containment. This approach rarely featured in the literature, however one study reported differences in opinion amongst clinicians; some believed people should be allowed to self harm during an admission, and felt this would help to reduce overall rates of self harm, whilst others advocated the use of observation and restraint to prevent self harm. These issues were not explored in any detail (Sandy & Shaw, 2012). Birch et al., (2011) examined the use of harm minimisation within a female forensic service providing support on two wards and also accommodation in the community. Rates of self harm were recorded over a period of six years and there was a significant decrease in the number of incidents during an admission. However, this study only involved a small number of service users (n=45), and no controls.

In summary, current evidence for the use of containment measures for self harm is weak. Some findings suggest these approaches are associated with increased self harm, however, because most studies used correlational designs, the direction of this relationship is unclear. Qualitative studies frequently reported staff concerns about these measures, but that many felt they had no alternative ways to ensure people's safety. Service users found containment measures distressing, and some felt they increased their desire to self harm. Very few studies investigated the use of a harm minimisation approach, which, in some cases, may provide an alternative for the use of these practices.

1.10.2 Psychosocial interventions for self harm

Nurses felt that therapeutic interaction with service users was important, however felt their role was to provide more general 'support' rather than 'in depth' therapeutic work, which was seen as the role of a specialist (O'Donovan, 2007). Consequently data regarding the therapeutic work undertaken by nursing staff did not relate to specific, structured interventions for self harm, but more the nature and content of interactions between staff and service users. Staff said they spent 15 to 90 minutes each day providing 'support' to service users, which included instilling hope, finding a solution to self harming behaviour, listening to people's problems, focussing on life outside of

hospital, reinforcing positive thinking, encouraging alternative ways of self expression and conducting stress-management and assertiveness training (O'Donovan, 2007; Sandy & Shaw, 2012). They believed it was important to work alongside service users, which meant viewing them as the experts in their experiences, and offering them some control over their care. They felt this approach helped to reduce self harm, and were critical of 'rigid and authoritative' practices, adopted by some of their colleagues (e.g. 'telling [service users] what to do'; Sandy & Shaw, 2012). Lindgren et al's (2011) observational study included an in depth analysis of staff-service user interactions, and identified two 'repertoires' (a 'fostering repertoire' or a 'supportive repertoire') which represented staff interactions with service users. A fostering repertoire described those who took an authoritative position, which meant they valued their own opinions over the service users', and took all decisions regarding their care. These staff enforced rules about what was acceptable and unacceptable behaviour. Contrastingly, those who adopted a supportive repertoire saw themselves and service users as equals. In their interactions they offered support, positive feedback, and showed concern for people around them. Service users found they benefited from supportive repertoires, whilst fostering repertoires were unhelpful.

Very few studies evaluated the outcomes of structured interventions for self harm; those which did are summarised in Table 6. It is difficult to determine the effectiveness of the majority of these interventions because of major methodological weaknesses in these studies. Most did not use a control group, had small sample sizes, were poorly described, and several did not employ any statistical analysis of the data. Bellus, Vergo, Kost, Stewart, and Barkstrom (1999), reported a significant reduction in rates of self harm following the implementation of a behavioural rehabilitation programme, which were also significantly lower than a control group receiving traditional care over the same time period. However, the intervention was targeted at people with specific cognitive impairments, and so the results are not generalisable to a typical ward population. Bisconer et al. (2006), showed a reduction in self harming behaviour following the implementation of a behaviour plan, but this was used with only one individual. The most robust data were regarding the effectiveness of dialectical behavioural therapy (DBT). Low, Jones, Duggan, Power, and MacLeod (2001), found significant reductions in self harm amongst 10 women with a diagnosis of borderline personality disorder, 6 months after a course of DBT. There were also significant reductions in dissociative experiences, and increases in survival and coping beliefs. Similarly Booth, Keogh, Doyle, and Owens (2014), developed a modified version of DBT, more suited to acute care. They reported a significant reduction in self reported incidence of self harm at 3 month follow up. These

data provide some preliminary evidence for the effectiveness of DBT, however larger trials with control groups are necessary to provide robust evidence.

Three studies evaluated interventions which aimed to improve nursing care on the ward in general, and measured their impact on rates of self harm amongst other outcomes. Fletcher and Stevenson (2001), reported preliminary findings of an evaluation of the 'Tidal model' of psychiatric nursing care, and following implementation on one ward, reported a 6% reduction in episodes of self harm. However, the authors did not provide any statistical analysis of this data, nor did they report the numbers of incidents of self harm pre and post implementation. Bowers, Flood, Brennan, LiPang, and Oladapo (2006), evaluated a project where two specialist 'City Nurses' were recruited to bring about a change in practice on two acute psychiatric wards in accordance with the 'City Model' of nursing care. There was a significant reduction in the mean number of incidents of self harm per shift following implementation of the intervention, and a reduction in the mean number of suicide attempts per shift (but not statistically significant). This study was repeated some years later, when the intervention was implemented on three wards, and data collected from a further five control wards. There was a decrease in the mean number of suicide attempts and incidents of self harm per shift, however neither change was significant, and did not differ significantly from control wards (Bowers, Flood, Brennan, & Allan, 2008).

In summary, inpatient nursing staff felt their role was to provide general 'support' to people who self harm, rather than structured psychosocial interventions. Accounts of nursing 'support' were wide ranging, but meant working alongside service users, rather than taking an authoritative approach. There are currently very few evidence based approaches for supporting people who self harm within an inpatient setting, and little research in this area. Offering a course of structured therapy within these services can be difficult because people are unlikely to be on the ward for a long enough period of time; the median length of stay in inpatient services is around three weeks (Health and Social Care Information Centre, 2014), however, there was an example of how traditional therapies can be adapted for these settings, and some preliminary evidence that this type of approach may be beneficial.

Table 6. Intervention studies

Study	Setting	Intervention	Design	Sample	Outcome
Bellus et al. (1999)	Acute; USA	Behavioural Rehabilitation and Interpersonal Treatment Environment (BRITE), 2 year implementation period: rewards for adaptive behaviours and fines for maladaptive behaviours, plus 50 hours of rehabilitative services/week.	Before (6 months) and after, with controls.	Non random sample of 32 people with cognitive impairments.	Significant reduction in rates of self harm. Rates of self harm amongst the program group were significantly less than rates amongst controls at the end of the study period
Bisconer et al. (2006)	Acute; USA	Behaviour plan, 39 month implementation period: Rewards for adaptive behaviours, and absence of maladaptive behaviours. Staff trained to recognise antecedents to maladaptive behaviours and provide consistent responses to target behaviours.	Before (3 months) and after, no control	One male with a diagnosis of schizoaffective disorder, mild mental retardation, and seizure disorder.	Over a 50% reduction in incidents of self harm (no statistical tests reported)
Booth et al., (2012)	Acute, Ireland	The Living Through Distress Group, 24 sessions (1 hour) over 6 weeks. Adapted from a DBT skills training group run by clinical psychologists. Taught eight skills: self-soothe; wise mind; mindfulness; labelling emotion; opposite action; distraction; radical acceptance; and building a life worth living.	Before and after, including 6 month follow up	144 acute service users with a history of self-harm, or seen to have strong ideation or risk of self harm.	Significant reductions in participants' reports of self-harm and significant increases in their distress tolerance levels, maintained at 3-month follow-up. Reduction in mean number of inpatient days at 1-year and 2-year follow-up.
Bowers et al.(2006)	Acute; UK	The City Model, 1 year implementation period. Critical features: staff's positive appreciation of service users, management of emotional responses to service users' behaviour, effective rules and routines. Two city nurses employed to work with wards, assisting with the implementation of the intervention.	Before (3 months) and after, no control	All admissions to 2 acute psychiatric inpatient wards during one year.	Significant reduction in mean incidents of self harm per shift. Reduction (but not significant) in number of suicide attempts/shift.
Bowers et al.(2008a)	Acute; UK	As above	Before and after comparison, with controls.	All admissions to 3 intervention and 5 control acute wards during the study period.	Decrease in incidence of self harm (not significant), no significant difference from control wards.
Fletcher & Stevenson (2001)	Acute; UK	The Tidal Model. Critical features: active collaboration with the individual and family, service user empowerment, integration of nursing with other disciplines, resolution of problems through narrative based interventions.	Before (6 months) and after, no control.	All admissions during a 6 month period before implementation of the Tidal Model (excluding transfers to the ward; n=69)	A 6% reduction in rates of self harm (no statistical tests reported)
Low, et al (2001)	Forensic; UK	Dialectical Behavioural therapy, 1 year implementation period: weekly individual psychotherapy sessions, combined with group behavioural skills training	Before (3 months), after, 6 months post treatment comparison. No control.	10 female patients with a diagnosis of borderline personality disorder	Significant reduction in rates of self harm between pre, and end of treatment blocks, rates remained significantly lower 6 months post treatment.

1.11 Organisational issues

A number of qualitative studies featured some discussion of how organisational issues impacted on the quality of care delivered by inpatient services. In all studies, nurses expressed dissatisfaction with their current practice but felt there was little they could do to improve it. Staff felt that organisational pressure to 'fix' people who self harmed meant that staff had unrealistic expectations of service users (Sandy & Shaw, 2012). Other issues such as insufficient support structures, lack of consistency of nursing staff, lack of autonomy, and a lack of resources had a negative impact on the quality of care, as did the nature of the ward environment which meant nurses had limited time to support those who self harmed (O'Donovan, 2007; O'Donovan & Gijbels, 2006; Smith, 2002; Wilstrand et al., 2007). Staff felt a medication based approach was dominant, which made it difficult to use the person centred model they preferred (O'Donovan & Gijbels, 2006). Staff found it difficult to negotiate the different roles they had to adopt whilst caring for those who self harm. These included negotiating boundaries of closeness to, but also distance from the service user, caring for the service user, as well as not giving them too much attention, and ensuring their safety, as well as maintaining their dignity (O'Donovan, 2007; Wilstrand et al., 2007). Nurses felt that, ideally, people should be cared for in small, specialist units, and that adequate finances, more time to spend with service users, specialist staff and regular staff supervision would help to improve the care provided for those who self harm (Wilstrand et al., 2007).

1.12 Staff perceptions of self harm

Data regarding staff perceptions of self harm were obtained from attitude measures, or qualitative interviews and focus groups. Survey studies are summarised in Table 7, and explored relationships between staff attitudes and characteristics, including demographics, training, and clinical experience. On the whole, the quality of these studies was poor, most used measures which had not been designed for use amongst specialist mental health staff, and used only univariate statistics to explore relationships between these variables.

Hauck, Harrison, and Montecalvo (2013) investigated staff views of self harm amongst people with a diagnosis of Borderline Personality Disorder. The authors used the Attitudes Towards Deliberate Self Harm Questionnaire (ADSHQ), which was designed for use within general medical settings (McAllister et al., 2002), and so its validity as a measure of attitudes amongst specialist mental health staff is questionable. The authors reported relatively positive mean scores and a significant correlation

between years of service and a subscale measuring staff 'ability to deal effectively with deliberate self-harm patients', but no effects for age, gender, educational level, years of service and frequency of patient contact. Kool, van Meijel, Koekkoek, van der Bijl, and Kerkhof (2014) also used the ADSHQ, but to evaluate the effects of a training programme on staff attitudes towards self harm. The study adopted a pre/post design and collected information about self efficacy and 'distance/closeness' in the staff-service user relationship (Table 7). The training programme aimed to develop staff's understanding of some of the difficulties service users may have in coping with their emotions, and the relationship between emotions and self harming behaviour. It also aimed to help them understand their own feelings and thoughts about self harm, and how this might influence their practice. The training programme was delivered by a person with lived experience of self harm together with a nurse, and featured an exhibition of art produced by service users. Initial attitude scores suggested relatively positive attitudes amongst this group. Four weeks after training the researchers observed statistically significant improvements in scores for attitude, self efficacy and staff-service user relationship, with the greatest improvements in self efficacy.

Gibb et al. (2010), designed their own measure of staff attitude towards self harm, but gave very little information about how it was developed. The measure had low face validity because it included questions which referred to 'self harm' and others 'attempted suicide', which indicated that these behaviours are different, yet measured attitudes towards them in a single scale. Staff characteristics (age, gender and education) were not significantly associated with attitude score, however the authors did report a significant positive correlation between Maslach Burnout Inventory sub score for 'confidence and training' and emotional exhaustion.

Wheatley and Austin-Payne (2009), was the only study to use a case vignette to measure staff views of self harm. They manipulated the controllability (recent bereavement vs debt) and stability (first episode vs sixth episode) of self harm, and collected information about staff attitudes and knowledge, helping behaviour, and emotional response to self harm. This study used more robust measures than those previously described, however only achieved a 12% response rate. The sample had low mean scores for negativity and high scores for effectiveness. There were no significant differences in attitude by gender and experience, however unqualified staff had higher scores for worry and negativity compared to qualified staff. The authors found lower ratings of control over self harm were significantly associated with increased scores for sympathy, pity and helping behaviour. The average score on the knowledge questionnaire was 64% and there were no significant differences in scores between qualified and unqualified staff.

Table 7. Survey studies of staff attitudes

Study	Sample size (response rate)	Service type	Occupation	Measures
Hauk et al., (2013)	83 (66%)	Acute	Mental Health Nurses	Adapted version of the Attitudes Toward Deliberate Self Harm Questionnaire (ADSHQ)
Gibb et al., (2010)	195 (64%)	Acute	Doctors; Mental Health Nurses	Attitude towards self harm questionnaire (designed by authors); the Maslach Burnout Inventory
Wheatley et al., (2009)	76 (12%)	Acute	Mental Health Nurses; Healthcare Assistants	A case vignette; adapted version of the Attributional Style Questionnaire (ASQ); the Emotional Response Rating Scale, Crawford's self harm knowledge and attitude questionnaire
Kool et al., (2014)	281 (49%)	Acute and forensic	Mental Health Nurses; Healthcare Assistants; Occupational Therapists; Social Workers	The Attitudes Toward Deliberate Self Harm Questionnaire (ADSHQ); the Self-Efficacy in Dealing with Self-Harm Questionnaire (SEDSHQ); the Patient Contact Questionnaire (PCQ)

Whilst survey studies reported relatively positive attitudes amongst inpatient staff, common themes emerging from qualitative studies were negative perceptions of self harm, and difficulties in providing support. Qualitative studies are summarized in Table 8. All used interview or focus group data, and were generally well described. There were no major differences or contrasting data in the themes emerging from these studies, so their results are considered together.

Staff identified self harm as a common characteristic of people they found most difficult to work with, and described this work as both challenging and frustrating (Breeze & Repper, 1998). Some felt that people who self harmed were distinctly different from other service users, and believed that others received a better standard of care (Sandy & Shaw, 2012). Some felt concerned that there was a risk of '*attitudes in traditional mental health setting, confirming [the service users'] early negative experiences*' (Smith, 2002). Negative attitudes included viewing those who self harmed as manipulative, a nuisance, 'attention seekers', failures, 'timewasters' and underserving of care (Sandy & Shaw, 2012; Wilstrand et al., 2007). Some saw self harm as a 'forceful action' towards others (Wilstrand et al., 2007), whilst others overheard colleagues asking people to wait and self harm when they were not around (Sandy & Shaw, 2012). Self harm had a significant emotional impact on staff. Nurses described feeling fearful that someone they were caring for may take their own life. They felt overwhelmed and powerless, which led to feelings of frustration. Some staff felt it unfair that they were exposed to self harm, and those who viewed self harm as an attempt to manipulate them, felt cheated. Because of

these experiences, staff sometimes became angry with service users and described seeing their colleagues lose control of their emotions. Nurses attempted to manage their emotions by shutting off their feelings and viewing self harm as just 'part of the job' (O'Donovan & Gijbels, 2006; Wilstrand et al., 2007), or by joking with the service user. When discussing those who had attempted suicide, participants explained they found it particularly difficult to assess and care for people who did not communicate their feelings, and did not interact with others. They felt unable to help some people change their suicidal behaviour, and believed it was inevitable that some would eventually take their own life (Carlen & Bengtsson, 2007). Some staff found it difficult to understand self harm, they felt they did not have enough knowledge about it, and did not know how to care for those with complex problems (Sandy & Shaw, 2012; Wilstrand et al., 2007). All studies highlighted a need for further training, and felt it was important that this examined practitioner's thoughts and feelings about self harm (Smith, 2002). Despite these challenges, there were examples of nurses who took pride in their work and valued the opportunity to support people during a difficult time in their life (Wilstrand et al., 2007)

In summary, data from survey studies was limited, but suggests relatively positive attitudes amongst inpatient staff. There were no significant effects for most staff characteristics, but some evidence that clinical experience and training are associated with more positive attitude scores. In contrast, themes reported in qualitative interview and focus group studies reflected negative perceptions of people who self harm, and additional challenges experienced by staff such as negative emotional responses to self harm and difficulties understanding the behaviour.

Table 8. Qualitative studies exploring staff views of self harm

Study	Service type	Occupation	Sample size	Methods
Carlen et al., (2007)	Acute	Mental Health Nurses	11	Interviews, latent content analysis
Smith (2002)	Acute	Mental Health Nurses; Doctors; Psychotherapists; Occupational Therapists	15	Interviews, thematic content analysis
O'Donovan & Gijbels (2006)	Acute	Mental Health Nurses	8	Interviews, thematic content analysis
Breeze & Repper (1998)	Acute	Mental Health Nurses	9	Focus group, Grounded Theory
Sandy & Shaw (2012)	Forensic	Mental Health Nurses	25	Interviews and focus groups, Interpretive Phenomenological Analysis
Wilstrand et al., (2007)	Acute	Mental Health Nurses	6	Interviews, content analysis

1.13 Costs

Very few papers contained information about the costs of self harm. One study interviewed staff about the resources typically used to deal with incidents in terms of numbers, skill mix and time of staff involved, medication and administration costs. The authors estimated that self harm had a mean cost of £62.52 per event, £22.40 per day (based on a rate of 0.36 episodes/day), £8.2k per ward per year and just over £4 million per year across England (Flood, Bowers, & Parkin, 2008). One study found that 84% of psychiatric nurses had witnessed mild self harm, 57% severe self harm and 68% a suicide attempt in the past year, and reported a small, but significant, positive correlation between experience of mild or severe violence against self or a suicide attempt and number of days off work sick (Nijman, Bowers, Oud, & Jansen, 2005).

1.14 Summary and recommendations for future research

A systematic review of over 50 year's research identified just 56 studies which primarily focussed on inpatient self harm. On the whole, the data were limited by small, non-random samples, restricted (descriptive or univariate) statistical analysis, and poor

quality measures. Progress was hindered further by a lack of consensus regarding the definition of self harm, which is a long standing issue in this field (De Leo, 2006; Muehlenkamp, 2005). Current US and UK clinical guidance use different definitions of these behaviours, namely 'deliberately inflicting damage, pain, or both to one's bodily tissue without suicidal intent' (American Psychiatric Association, 2013) and 'any act of self-poisoning or self-injury carried out by an individual irrespective of motivation' (National institute for Health and Care Excellence, 2011). However, very little is known about how these terms are applied in practice. This information would enable researchers to make more informed choices about the definitions adopted in their studies. It is particularly important to identify if, and how, clinicians distinguish between acts of attempted suicide and self harm, because the ways in which these terms are defined are likely to have an impact on practice (i.e. a nurse would respond differently to an 'attempted suicide' compared to an episode of 'self harm'). Currently, there is little research in this area. Whisenhunt, Changg, Brack, Orr, and Adams (2012), surveyed a self-selecting sample of 31 American counsellors, and found that just under half believed self harm was different from an attempted suicide, or was not suicidal in nature. These findings indicate that, amongst these practitioners, there was no common understanding of these behaviours. However, there has been no research into how these terms are used within inpatient services, or amongst any clinicians in the UK.

A significant gap in the literature is the lack of national data regarding the characteristics of inpatient self harm. Information about the objects used is particularly limited, which is surprising, given that one of the main ways of reducing the risk of self harm is to remove the means (Mann et al., 2005) and most services will have restrictions around the possession, or use, of a number of objects during an admission (Bowers et al., 2002). In addition, there was very little data regarding the lethality of self harm (i.e. the likelihood that it would result in death), which is a more accurate indicator of the level of risk associated with the behaviour compared to indicators of severity adopted by most studies (i.e. the severity of injuries sustained). A national study of the characteristics of self harm, which gives a detailed description of the objects used to self harm, and the lethality of these behaviours, would increase understanding of inpatient self harm and so inform the development of appropriate nursing interventions.

Studies investigating the demographic and clinical characteristics associated with inpatient self harm dominated the literature, yet there were few consistent findings. This may be because the vast majority of studies were conducted within single wards, and there are likely to be substantial differences in service user populations between studies. Self harm can include a wide range of different behaviours, which serve a variety of very different functions (Klonsky et al., 2003), and so it may be that these characteristics do

play a role, but only for certain forms of self harm. An alternative explanation is that most demographic variables and diagnoses are, in fact, not risk factors. Future research could focus on the role of social and psychological factors such as coping style, impulsivity, or exposure to negative life events, which were under researched, and have been shown to be related to self harm in community samples (O'Connor et al., 2009).

One relatively consistent finding was a higher prevalence of aggressive behaviour amongst people who self harmed during an admission, compared to those who did not. Self harm can be viewed as an 'inwardly directed' form of aggression (Sorgi, Ratey, Knoedler, Market, & Reichman, 1991) and it has been suggested that, in some cases, the underlying motivations for these acts may be the same (Plutchik, 1995). This finding suggests that these behaviours are closely related. An alternative explanation, however, is that these behaviours are reported differently by different staff. It may be that more aggressive forms of self harm, such as head banging, punching or kicking, which often featured in studies (Table 4) were sometimes documented as aggression (e.g. against an object), rather than self harm, which would explain the association between the two behaviours.

Qualitative studies examining the experiences of inpatient staff revealed some complex issues. Staff found self harm difficult to understand, and there was evidence that some had developed negative attitudes towards those who self harmed in their care, however it is not clear why some nurses experience these difficulties. Contrastingly, quantitative studies reported relatively positive attitudes amongst inpatient staff, although most used measures which were not suitable for mental health professionals, and all were small samples, within single services. The reasons for differences in findings reported by qualitative and quantitative studies is unknown, however could be due to issues with the representativeness, or accuracy of the data. For example, a negative bias in reporting of qualitative data (due to a tendency to overemphasise negative views of self harm) or issues with the validity or reliability of the attitude measures used (such that they do not fully capture the attitudes of nursing staff). Negative attitudes amongst clinical staff are frequently cited as having a significant impact on the quality of care experienced by people who self harm (McHale & Felton, 2010; National institute for Health and Care Excellence, 2011; Royal College of Psychiatrists, 2010), and so it is important that the factors that may contribute to, or protect against, these views are understood, so they can be addressed during training and practice. Surveys using more robust measures, and with larger samples, are required to determine attitudes amongst inpatient staff, and the staff characteristics which may predict them. A qualitative study exploring how staff formulate their understanding of self harm would also help to develop a more in depth understanding of factors which may contribute to the development of

negative perceptions of self harm. A rigorous mixed methods study of this type may also help to explain discrepancies between the findings of qualitative and quantitative studies of staff attitudes.

Nursing staff employed a wide range of containment strategies to manage self harm, yet there has been very little research into their effectiveness. A common theme in the literature were concerns amongst both staff and service users that containment is detrimental to people's wellbeing, and may cause self harm to increase. A possible alternative to these practices is the harm minimisation approach, which negates the use of containment because people are not prevented from self harming, and instead, are supported to self harm in a safe way. This approach featured in just one study which had several limitations, but reported a decrease in rates of self harm on wards implementing the approach. Harm minimization is advocated by service users (Duperouzel & Fish, 2008; Pembroke, 1994), and was reviewed by recent NICE guidance, which recommended '*tentative approaches to harm reduction for some people'*, however made no recommendations about its use on psychiatric wards (National institute for Health and Care Excellence, 2011). This practice is likely to present a number of challenges to practitioners (Gutridge, 2010), particularly within inpatient services, yet there has been very little research into the views of staff. One study found that 85% of staff working in a forensic learning disability service were in favour of the introduction of a harm minimisation policy (Fish, Woodward, & Duperouzel, 2012), however the views of inpatient nursing staff are unknown.

1.15 Aims and significance of the study

This thesis focussed on a number of gaps in the literature identified in this systematic review. Specifically; the absence of any national data regarding the characteristics of self harm within inpatient studies, the limited understanding of inpatient staff attitudes towards people who self harm and how the terms 'self harm' and attempted suicide' are defined in practice, and the lack of research into staff views of harm minimisation practices. Aims were:

1. To describe the characteristics of self harming behaviour, and the interventions employed following self harm, within a national sample of inpatient services
2. To measure inpatient nursing staff attitudes towards people who self harm
3. To explore how inpatient nursing staff come to reach their understanding of self harm
4. To determine inpatient nursing staff views of harm minimisation practices

5. To explore if, and how, inpatient nursing staff distinguish between acts of self harm and attempted suicide

These aims were addressed in two studies, using a mixed methods approach; Study 1 was a documentary analysis of incident reports of self harm, and the first national study of its kind. Study 2 was a sequential explanatory study, conducted in two phases; a survey of inpatient staff attitudes towards people who self harm, using the Self Harm Antipathy Scale (SHAS; Patterson et al., 2007a), followed by interviews with staff, selected on the basis of their attitude scores. It was the largest survey of inpatient staff attitudes towards self harm to date, and the first in the UK to examine how acts of 'self harm' and 'attempted suicide' are defined in practice. Study 2 also explored views of harm minimisation practices within inpatient psychiatry, which again, had not been studied before.

3. Methods

3.1 Introduction and study aims

This thesis set out to address gaps in the literature identified following a systematic review of studies of inpatient self harm (Chapter

2). Specific aims were:

1. To describe the characteristics of self harming behaviour and the interventions employed following self harm within a national sample of inpatient services
2. To measure inpatient nursing staff attitudes towards people who self harm
3. To explore how inpatient nursing staff come to reach their understanding of self harm
4. To determine inpatient nursing staff views of harm minimisation practices
5. To explore if, and how, inpatient nursing staff distinguish between acts of self harm and attempted suicide

This chapter presents the methods used and rationale for selecting these approaches, starting with the methodological approach and philosophical basis of the thesis, the ways in which it has been informed by lived experience of self harm, and then for each study; an outline of the aims and research questions, the design and methodological procedures**,** a description of the analytical techniques used to answer the research questions, and an overview of ethical issues.

3.2 Methodological approach and epistemology

This thesis adopted a mixed methods approach and consisted of two studies; Study 1 investigated the prevalence of various characteristics of self harming behaviour within inpatient mental health services across the UK through a cross-sectional, documentary analysis of incident reports. Study 2 was a sequential explanatory study of nursing staff attitudes towards self harm composed of two phases; Phase I measured staff attitudes and their relationship to staff characteristics using a self-report Likert Scale, and Phase II was an in depth qualitative interview study of staff understandings of self harm.

To date there have been few mixed methods studies of self harm. Current research largely comprises self report survey studies (e.g. Klonsky, 2011; Muehlenkamp, Brausch, Quigley, & Whitlock, 2013), or epidemiological studies of people attending accident and emergency departments (e.g. Bergen, Hawton, Waters, Cooper, & Kapur, 2010; Zahl & Hawton, 2004). Mixed methods research is a relatively new discipline, which operates across the philosophies underpinning qualitative and quantitative research. Traditionally, the social sciences have been dominated by two opposing philosophical positions; positivism and constructionism. Positivism asserts the existence of 'social facts' that occur independently of the actions of researchers. Whist constructionism states that there are no 'social facts', and instead, multiple forms of social reality which are constructed by researchers and their participants. These issues are important as they have implications for the methodological decisions that are made during a research study. For example, positivists believe the best way to investigate social phenomena is to apply the research methods adopted by the natural sciences, whilst constructionists encourage researchers to investigate social phenomena by studying the content of interaction.

Historically, many social scientists were advocates of the 'incompatibility thesis', which states that qualitative and quantitative methods should not be mixed because their underlying assumptions about the nature of knowledge are incompatible (e.g. Guba, 1987). This meant researchers were often instructed to situate themselves within one philosophical paradigm, and so those using quantitative methodologies were positivists and those using qualitative methods, constructionists. In recent years however, there has been a substantial increase in the number of studies adopting a mixed method approach, which is now welcomed by funding programmes (O'Cathain, Murphy, & Nicholl, 2007), and has been cited as the 'third major research paradigm', alongside quantitative and qualitative methods (Johnson, 2007). Mixed methods research can be defined as:

"research in which a researcher or team of researchers combines elements of qualitative and quantitative research approaches (e.g., use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the broad purposes of breadth and depth of understanding and corroboration."
(Johnson, Onwuegbuzie, & Turner, 2007, p. 123)

Mixed method researchers are primarily concerned with selecting the best method for answering a research question, and so rather than aligning themselves with a particular ontological perspective, are able to work across both positivist and constructionist

worldviews (Johnson & Onwuegbuzie, 2004). Philosophical issues about the nature of knowledge are still considered, but are used to inform, rather than dictate, their choice of methods, allowing researchers to draw upon the strengths of both research paradigms (Morgan, 2007). Mixed method studies are particularly prevalent in applied settings, such as health or social care, where researchers are interested in practical, rather than philosophical questions (Tashakkori & Teddlie, 2003). As such, the philosophical paradigm adopted by mixed methods research (and throughout this thesis) is pragmatism (See Johnson & Onwuegbuzie, 2004, Table 1).

3.2.1 Involvement of people with lived experience

It is now widely accepted that involving people with lived experience of mental health problems in the design, and where possible, delivery, of mental health services research ensures the research is ethical, relevant, and ultimately leads to better quality studies (Ennis & Wykes, 2013). This approach is advocated by the Department of Health and major funding bodies in the UK (Department of Health, 2000). This thesis was guided by input from SUGAR (Service User and Carer Group Advising on Research), an advisory group at City University, London (Simpson, Jones, Barlow, & Service User and Carer Group Advising on Research (SUGAR), 2014). SUGAR members include people who have previously been admitted to inpatient services, people with lived experience of self harm, and people who have supported family members who self harm. SUGAR were involved throughout the course of this research, from the design of the research questions, to the interpretation of findings. For example, the group suggested an additional research question around staff views of harm minimisation practices, which was not an original aim of this thesis.

3.3 Study 1: An analysis of incident reports of self harm

3.3.1 Aims

The aim of Study 1 was to describe the characteristics of self harming behaviour, and the interventions employed following self harm, within a national sample of inpatient services.

3.3.2 Research Questions

1. What are the characteristics of self harm within inpatient psychiatry, as documented in incident reports of self harm?
2. What are the antecedents to self harm?

3. What interventions are employed following self harm?

3.3.3 Study Design

Study 1 constituted a cross-sectional documentary analysis of incident reports of self harm. Documentary analysis is a non-reactive form of qualitative analysis, which involves the study of either the content, or function, of documents (Scott, 1990). Health services record a large amount of information about service user care in documents, which have been subject to documentary analysis, including clinical guidance (van der Ham, Shields, van der Horst, Broerse, & van Tulder, 2013), policy documents (Borrell et al., 2012), nursing notes (Davis, Billings, & Ryland, 1994) and health assessments (Hill & Watkins, 2003). In this study the data were incident reports obtained from the National Reporting and Learning System (NRLS). The NRLS was set up in 2003 by the National Patient Safety Agency (NPSA) as a national database used to collate incident reports from local NHS Trusts (Williams & Osborn, 2006). A documentary analysis has several major advantages over alternative methods of collecting data regarding incidents of self harm such as interviews, surveys, or observations of incidents on wards, as firstly, it allows the researcher to draw from a national sample. Secondly, it forgoes the lengthy processes of participant recruitment and data collection, enabling the researcher to analyse a large amount of data in a shorter period of time. And finally, incident reports are typically written soon after the incident has occurred, and so are likely to give a more accurate description of the event than interview or survey data. One important limitation of documentary analysis, however, is that because these documents are produced as part of the day to day running of a ward, rather than a research project, there can be problems with the accuracy of the data. Scott (1990) identifies four criteria for assessing the quality of documents as sources of data:

1. Authenticity: Is the evidence genuine and of unquestionable origin?
2. Credibility: Is the evidence free from error and distortion?
3. Representativeness: Is the evidence typical of its kind?
4. Meaning: Is the evidence clear and comprehensible?

When considering official documents such as the NRLS incident reports, it is reasonable to assume that the data are authentic and meaningful. The main concerns, therefore, are its credibility and representativeness. Incident reports are intended to give an objective account of the event, however may be subject to bias because they do not include the service user's perspective and, where there has been a serious incident of self harm, nursing practice (as documented in the NRLS) will come under scrutiny. In such cases it

is likely that staff will feel under pressure to represent their practice in the best possible light. This possible source of bias is unlikely to impact the validity of data regarding the more distinct characteristics of self harm, such as the method used or the time of day, but may be an issue when considering the wider context of the incident, for example, the antecedents to the event. This issue is discussed further in section 7.3. A further limitation is that the data may not include all the information needed to answer the research question (Fitzgerald, 2007). NRLS reports include demographic information about the patient involved (e.g. gender, ethnicity, age), and detail regarding the broader context of the incident, which has been used for analysis in previous research (Cassidy, Smith, & Arnot-Smith, 2011). This data is unlikely to be missing as incident reports serve as an official record of the event, and most of this information (e.g. demographic data) is compulsory. Regarding the representativeness of the data, previous research has found that incidents do tend to be underreported within general health services (Sari, Sheldon, Cracknell, & Turnbull, 2007) and whilst there is some anecdotal evidence of underreporting of aggressive incidents within community mental health services (Fry, O'Riordan, Turner, & Mills, 2002), there have been no comprehensive studies of incident reporting within inpatient care, and no data in relation to the reporting of self harm. An analysis of nursing notes, rather than official incident reports, may have been a more representative source of data, however obtaining a national sample of nursing notes would have been extremely difficult, and so for pragmatic reasons, the NRLS database was considered the best data source for this study.

3.3.4 Sample

A random sample of 500 reports was selected from a total of 14,271 reports of self harm occurring within psychiatric inpatient services between 01st January 2009 and 31st December 2009. Given the paucity of research in this field, and because this was an exploratory study, a sample size calculation was not performed. A sample of 500 reports was selected as it was considered to be a manageable number to analyse given the time constraints of the project.

'Self harm' is defined on the NRLS eform as: '*A patient deliberately attempting to damage themselves without intending to die*' (National Patient Safety Agency, 2014). The majority of trusts, however, do not use this form to report, and in such cases the definition of self harm is unknown. When reporting an incident of self harm, the clinician indicates whether it is an act of self harm or attempted suicide. Because this study is interested in examining the characteristics of what is defined as 'self harm' within clinical practice, reports of 'attempted suicides' are not included in this analysis.

Inclusion criteria were:

> Reports of self harm occurring in mental health inpatient, intensive care units, secure units or wards, classified as one of the following specialities: adult mental health, forensic mental health, mental health rehabilitation or older adult mental health.

Exclusion criteria were:

> Reports of behaviours that did not fall under the definition of 'self harm' used within clinical practice in the UK (National institute for Health and Care Excellence., 2011).

3.3.5 Data Management

Incident reports were selected and extracted from the NRLS by NPSA staff. Reports were sent to the student via a secure connection. All data were entered into SPSS Version 18.0 for analysis.

3.3.6 Analysis

The NRLS database contained separate fields holding the following information; care setting of occurrence, date of incident, time of incident, age at time of incident, gender, ethnicity, and staff rating of the severity of the act (Table 9). This data was extracted directly from the NRLS for analysis. Any additional information was included in a free text field 'description of what happened'. A content analysis of this field was conducted to obtain further information about the antecedents to, and characteristics of self harm, and the interventions employed by staff. For this study, content analysis was employed as "*a research technique for the systematic, objective and quantitative description of the manifest content of communication*" (Berelson, 1952). Content analysis was selected because it is a robust, and replicable method of extracting information from a text, without distorting the original data (Krippendorff, 1980).

Table 9. National Patient Safety Agency definitions of levels of severity of patient safety incidents

Severity rating	Criteria
None	A situation where no harm occurred: either a 'prevented patient safety incident' or a 'no harm patient safety incident'
Low	Any unexpected or unintended incident which required extra observation or minor treatment and caused minimal harm, to one or more persons
Moderate	Any unexpected or unintended incident which resulted in further treatment, possible surgical intervention, cancelling of treatment or transfer to another area and which caused short-term harm, to one or more persons
Severe	Any unexpected or unintended incident which caused permanent or long-term harm, to one or more persons
Death	Any unexpected or unintended incident which caused the death of one or more persons

3.3.6.1 Procedure for content analysis

A random sample of 100 reports were read and the following coding categories identified: location of the incident, method of self harm, objects used to self harm, antecedents to self harm, containment measures in place at the time of self harm, and staff interventions following self harm. All reports were then read and coded using the categories described above. Subcategories were then generated from the data using the processes of condensation (shortening the data, whilst preserving its core meaning) and abstraction (describing the data under higher order headings), as outlined by Graneheim and Lundman (2004). Table 10 gives examples of this process.

Table 10. Generation of categories during content analysis

Unit of data	Method extracted	Method condensed (1)	Method condensed (2)	Sub-category
[Patient name] went into the bathroom and refused to come out, staff opened the door and found [patient name] standing near to the wall and ligature around her neck with shoelace and micropore tape. Staff removed ligature with knife and taken her to her room, spent 1:1 time.	Ligature around her neck with shoelace and micropore tape	Self ligature	Strangulation	Restricting breathing
Patient was found lying on the floor of his bedroom during intermittent obs. Staff shouted his name but there was no response. He had a transparent plastic bag over his head and a belt tied tightly around his neck and wrapped around his right hand. The alarm was raised and the bag and belt were immediately removed.	A transparent plastic bag over his head and a belt tied tightly around his neck and wrapped around his right hand.	Bag over head, tied around neck	Suffocation	
[Patient name] made a ligature from her pyjamas and tied them to the sink in her side room and around her neck. Staff carrying out observations alerted further ward staff who made an airway pulling the pyjamas away from her windpipe and cut pyjamas using ligature knife	Ligature from her pyjamas and tied them to the sink in her side room and around her neck	Ligature, tied to ligature point	Strangulation	

3.3.6.2 The Lethality of Suicide Attempt Rating Scale

In order to determine the severity self harm, the lethality of each act was scored using the Lethality of Suicide Attempt Rating Scale (Smith et al., 1984). This is an 11 point scale which takes into consideration the lethality of the method used, and the circumstances surrounding self harm (such as the likelihood of someone being discovered). The scale ranges from 0-10; a score of 0 represents an act where '*death is an impossible result of the suicidal behaviour'*, and a score of 10 where *'death is almost a certainty regardless of the circumstances or interventions by an outside agent'*. The scoring system was adapted to take into account unique circumstances within psychiatric inpatient care. The amended score demonstrated acceptable inter-rater reliability (see Bowers et al. (2011) for a detailed description of these amendments).

3.3.6.3 Development of 'Openness scale'

As self harm is sometimes used as a way of communicating with, or changing the behaviour of others (Klonsky, 2007), the social nature of self harming behaviour was investigated by devising a scoring system called the 'Openness scale' (Table 11). This is a five point scale which reflects how publicly, or 'openly' a person self harms. Scores range from 0-4, where a score of 0 represents 'closed' self harm, and a score of 4 'open' self harm. Where there was any ambiguity as to the context of self harm, the report was not scored. Cases where the service user was under constant observation were excluded from the analysis because the person would not have had the option to self harm in private.

Table 11. The Openness score

Criteria	Score
In front of staff AND threats to self harm, and/or overt display of harm (including making loud noises, other aggression, gesturing)	4
In front of staff (aware that staff are watching)[1]	3
In public area (not in front of staff)	2
In private but then approach staff to notify them OR in private and then call for help	1
In private	0

1. Service users who self harmed when under intermittent observation were given a score of 2, except in cases where there was an attempt to conceal actions from staff, which were given a score of 0

3.3.6.3.1 Inter-rater reliability

Inter-rater reliability evaluates the extent to which independent coders evaluate a characteristics of a message or artefact and reach the same conclusion (Krippendorff, 1980). This test helps to establish the validity of a content analysis by illustrating whether, or not, the results are replicable. A good agreement between raters indicates an objective and reliable coding fame.

To test the inter-rater reliability of the Openess scale, a random sample of 50 reports were independently scored by another researcher. The Kappa statistic was calculated to determine consistency between raters and indicated a moderate level of agreement (Kappa= 0.57; p = < 0.001; 95% CI = 0.45 - 0.63)

3.3.6.3.2 Statistics

Descriptive statistics were used to illuminate the basic features of the data (demographic characteristics, characteristics of self harm, interventions used to manage self harm), whilst inferential statistics (Chi-Squared, Fisher's Exact Test, Kruskal Wallis, Mann-Whitney, Spearman's correlation, Z-test of Equality Between Proportions) were used where appropriate, using SPSS Version 18.0, to reveal any relationships between these variables.

3.3.6.3.3 Ethical Considerations

This study was classified as a 'service evaluation', and so under UK regulations, ethical approval was not required. The NPSA removes all identifiable information from reports stored in the NRLS database, including any information that would identify service user, staff or the hospital. These reports were transferred via a secure, encrypted connection to the student, and were then stored in a password protected folder.

3.4 Study 2: An investigation of inpatient nurses' attitudes towards those who self harm

3.4.1 Aims

The main aims of study two were:

1. To measure inpatient nursing staff attitudes towards people who self harm
2. To explore how inpatient nursing staff come to reach their understanding of self harm
3. To determine inpatient nursing staff views of harm minimisation practices
4. To explore if, and how, inpatient nursing staff distinguish between acts of self harm and attempted suicide

3.4.2 Research Questions

1. What are the attitudes of inpatient nursing staff towards people who self harm?
2. Is the structure of the Self Harm Antipathy Scale (SHAS) identified by Patterson et al., stable across populations of inpatient staff?
3. How do staff perceptions of service users who self harm relate to their view of service users in general?
4. Are attitudes towards self harm a property of teams, or individuals?

5. How are attitudes towards people who self harm related to staff characteristics and wellbeing?
6. What is inpatient nursing staff's understanding of self harm?
7. How do staff come to reach their understanding of self harm?
8. Do nursing staff distinguish between acts of self harm and attempted suicide, and if so, how?
9. What are nursing staff's views of harm minimisation practices?

3.4.3 Study Design

For this study, a sequential explanatory design was adopted, characterised by two phases of data collection; a quantitative phase, followed by a qualitative phase. The purpose of this type of design is to use qualitative data to elaborate, or expand on, the findings of a quantitative study. For example, a specific trait of interest is identified using the quantitative data, and is then explored further in the following qualitative study (Creswell, Plano Clark, Gutmann, & Hanson, 2003). In this case, the initial quantitative phase constituted a survey of staff attitudes towards people who self harm. This aimed to measure the distribution of attitudes amongst nursing staff and its relationship to staff characteristics. In addition, Phase I provided a sampling frame for the selection of participants for Phase II (staff with the highest, and lowest attitude scores). Semi structured interviews conducted during Phase II aimed to provide more detailed, in depth, data regarding staff understandings of self harm and how these are formed.

Previous studies adopting this design have highlighted the importance of limiting the amount of time between phases. For example, Brannen, Dodd, Oakley, and Storey (1994) surveyed a group of London teenagers about their health, and then conducted in-depth interviews with a subsample of these teenagers between 6 and 25 months later. The researchers found inconsistencies between the interview and survey data, which may have been because the teen's health behaviours had changed during this time. Currently, there is no guidance as to what is an acceptable minimum amount of time between phases. This study aimed to conduct interviews no later than 9 months after the survey had been completed.

3.4.4 Context of the study

Study 2 formed part of Safewards; a large cluster randomised controlled trial which evaluated the effectiveness of a series of nursing interventions in reducing conflict and containment on inpatient psychiatric wards. All staff participating in Study 2 were recruited to the Safewards trial, and so the trial inclusion and exclusion criteria also

applied to this study (see section 3.4.6.2 for these criteria). The consent process for Study 2 was embedded within the Safewards consent procedures, and survey data collected during Phase I of Study 2 were part of a pack of questionnaires administered to all Safewards participants. Interview data for Phase II of the study were collected after the end of the trial, and from staff working on control wards only (see section 3.4.7.2).

The student played a key role in the set up and coordination of the Safewards trial. She delivered the trial pilot study and her feedback from this study was used to determine the protocols for recruitment and data collection for the main trial. During the trial set up phase she helped recruit Trusts by liaising with senior NHS staff. She designed and delivered a training programme to the trial Research Assistants, to maximise response rates and included techniques to overcome challenges she experienced when recruiting participants and collecting data during the pilot study (see section 3.4.6.4.1).

3.4.5 Ethical Considerations

The national standards for research in the National Health Service states that "*The dignity, rights, safety and wellbeing of participants must be the primary consideration in any research study*" (Department of Health, 2005, p. 7). This study did not involve any direct risks to participants, or the collection of patient data, and so the main concern was to obtain informed consent, and to protect the rights of participants throughout. All staff were given written information about the study, and the opportunity to discuss any concerns with the research team, who were present on the ward during recruitment and data collection. Staff were informed that their participation was voluntary, and that they could withdraw their consent at any time. Staff were allocated a research code, which was used to identify their questionnaire and interview. These codes were only accessible to members of the research team. Ethical approval for this study was obtained from the Dulwich Research Ethics Committee (REF 11/LO/0798).

3.4.6 Phase I

3.4.6.1 Pilot study

To test the feasibility of the procedures for recruitment and data collection a pilot study was conducted on four wards in East London. Seventy staff consented to participate in the pilot study. During Phase I, data were collected from 35 participants (48% return rate). As a result, strategies were put in place during the main study to maximise participation during Phase I (see section 3.4.6.4.1).

3.4.6.2 Sample

For Phase I, the sample constituted all nursing staff working on 31 acute psychiatric wards in 15 NHS hospitals situated in the South East of England, recruited as part of the Safewards Trial (UK Clinical Research Network Study Portfolio). Hospitals were randomly selected from a list of all hospitals with two or more potentially eligible wards within 100km of the centre of London by the King's Clinical Trials Unit. Wards were randomly chosen within hospitals (with replacements for those wards which could not commit or consent to the trial).

Inclusion criteria were:

> Acute psychiatric wards defined as wards that primarily serve people in mental health crisis, taking admissions mainly directly from the community. Specifically, admission wards, assessment wards, triage wards, treatment wards, pre-discharge wards, extra or intensive care; insofar as these wards provide whole or part of the acute care pathway for those temporarily admitted directly from the community. Wards were included regardless of the gender of patients to which they provide a service, whether male, female or mixed, and regardless of the ward's door locking policy.

Exclusion criteria were:

1. Wards with other specialist functions (e.g. forensic, long term care, older people, child and adolescent).
2. Wards with major planned changes during the trial (e.g. reconfiguration of catchment areas or patient populations, refurbishment, managerial restructuring).
3. Wards where two or more of the following apply:
    a. An acting ward manager, no ward manager in post, or cover from ward manager primarily responsible for another ward; unless the local organisational structure is that of one ward manager having responsibility for two wards.
    b. A locum consultant psychiatrist, where that post is the identified sole consultant responsible for inpatient care.

All permanent nursing staff (qualified nurses and healthcare assistants) working on the ward were eligible to participate in the study. Based on the 50% response rate achieved during the pilot study, the total sample was estimated to be at least 300 people, which

represents an appropriate sample for multiple regression and factor analysis of the thirty item Self Harm Antipathy Scale described below (Tabachnick & Fidell, 2005).

3.4.6.3 Instruments

The data collected during Phase I of Study 2, and corresponding instruments used, are outlined in Table 12. Copies of all questionnaires can be found in Appendix B. This section presents a discussion of issues of validity and reliability in relation to measuring attitudes, followed by a description of the measures used.

Table 12. Variables included in the analysis and corresponding instruments

Study variables	Instrument
Gender Age Ethnicity Marital Status Job Title Pay band Years in current post Years working in mental health Number of dependent children	Staff data questionnaire
Staff attitude towards people who self harm	The Self Harm Antipathy Scale
Staff attitude towards all service users	Attitude to Personality Disorder Questionnaire
Staff Wellbeing	The Short Form (36) Health Survey

3.4.6.3.1 Measuring attitudes

For this study, an attitude is described as an '*affect for or against a psychological object'*, which exists along a continuum, from strong intensity to weak (Thurstone, 1928). An attitude is a complex social phenomenon, which, in order to be measured, must be reduced to an abstract linear form. A criticism of this approach is that it is not possible to capture something as complex as an attitude using a single number, or scale (Pedhazur & Schmelkin, 2013). In his seminal paper on the measurement of social attitudes, Thurstone argues that:

"*The measurement of any object or entity describes only one attribute of the object measured. This is a universal characteristic of all measurement. When the height of a table is measured, the whole table has not been described but only that attribute which*

was measured. Similarly, in the measurement of attitudes, only one characteristic of the attitude is described by a measurement of it" (Thurstone, 1931, p. 19)

Measuring attitudes in this way allows researchers to examine the distribution of certain attitudes within a population, to compare this across populations and to examine how attitudes relate to other variables and change over time.

Self report rating scales are the most widely used method of measuring attitudes (Bryman, 2012). Unlike structured interviews, these are relatively low cost and easy to implement (Oppenheim, 2000). Rating scales can take many different forms. Most commonly used are the Likert Scale (Likert, 1932), and the Semantic Differential (Mehrabian & Russell, 1974). The Semantic Differential scale asks respondents to rate a concept along a set of bipolar adjectives (e.g. good/bad), and so captures the connotative meaning it has for them. The Likert Scale asks respondents to indicate their level of agreement or disagreement for a series of statements about a concept, and so measures the intensity of their feelings towards that concept.

A limitation of rating scales is that they are subject to sources of response bias. For example, Likert Scales may be vulnerable to acquiescence bias: a tendency for participants to agree with statements (Krosnick & Fabrigar, 2001). Other forms of bias include: central tendency (avoiding extreme categories), faking bad (intentional misrepresentation) and satisficing (not fully considering the questions before answering them). Response biases can be minimised if they are considered when designing the scale, for example, acquiescence bias can be addressed by including an equal distribution of items keyed in positive and negative directions, whilst central tendency bias can be minimised by using a seven point, rather than a five point Likert scale (Streiner & Norman, 2008). A particular issue when measuring attitudes amongst clinical staff is the tendency for participants to answer questions in a way that will be viewed favourably by others (i.e. demonstrate positive attitudes towards service users), known as the social desirability bias. Studies have shown that one way of reducing this effect is to ensure participant's anonymity (Booth-Kewley, Edwards, & Rosenfeld, 1992; Lautenschlager & Flaherty, 1990). Some of these problems of bias could also be avoided by using indirect, or implicit methods of measurement. When completing an implicit measure the participant is unaware of what is being investigated, and so is more likely to give honest answers. Examples of implicit methods include cognitive tests such as the affective priming task, the implicit association test and the emotional stroop test (De Houwer, Teige-Mocigemba, Spruyt, & Moors, 2009), or the use of vignettes. A number of studies have used contrastive vignette techniques to measure attitudes towards self harm (e.g. Huband & Tantam, 2000; Mackay & Barrowclough, 2005; Wheatley & Austin-

Payne, 2009). These techniques however, are limited to either measuring an overall attitude, or the impact of a number of contextual factors on attitude. In addition, studies using both implicit, and explicit, self report measures of attitude towards self harm have found that self report is equally as reliable as implicit measures of attitude (Knowles & Townsend, 2012).

For this study, the Self Harm Antipathy Scale (Patterson et al., 2007a), a Likert measure of staff attitudes, was adopted primarily because these type of scales are widely available, and relatively easy to administer to large samples of participants. Likert scales also enable the researcher to capture responses to a range of complex belief statements, not possible when using semantic differential scales, or indirect measures. As discussed above, strategies were used to reduce response bias in the design and administration of this scale, for example; it is a seven point scale, with items keyed in both a positive and negative direction, and to protect anonymity questionnaires were labelled with an ID number and returned in a sealed envelope via a deposit box (section 3.4.6.4).

3.4.6.3.2 Scale validity and reliability

To provide an accurate measurement of attitude, a scale must demonstrate validity and reliability. Validly refers to the extent to which one can be confident in the inferences drawn from test scores (Pedhazur & Schmelkin, 2013), whilst reliability is an assessment of the amount of error inherent in a scale (Streiner & Norman, 2008). Reliability and validity can be assessed using a range of criteria. For example, the following are outlined by Kodaka, Poštuvan, Inagaki, and Yamada (2011) in their review of scales that measure attitudes towards suicide:

1. Validity: adoption of the theoretical concepts of 'attitude' or 'attitude towards suicide'; utilization of extensive literature reviews, expert consensus and/or focus group interviews during the process of scale development; interpretable results of factor analysis; correlations with external criteria; and any other information.

2. Reliability: internal consistency (e.g. Cronbach's α); stability (e.g. results of test-retest or split-half reliability tests); reproducibility (e.g. replication of factor structure among different populations); and any other information.

(Kodaka et al., 2011, p. 340)

See section 3.4.6.3.3 for a description of how the SHAS demonstrates validity, and section 3.4.6.6, for a detailed description of how tests of reliability were applied during this study.

3.4.6.3.3 The Self Harm Antipathy Scale

Staff attitudes towards people who self harm were measured using the Self Harm Antipathy scale (SHAS; Patterson et al., 2007a; Appendix B). The authors define 'antipathy' as "*a relatively stable negative individual attitude towards people who self harm which the nurse takes from one relationship with a self harming person to the next"* (Patterson et al., 2007a, p. 439). The SHAS is a 30 item self-report questionnaire, consisting of statements about people who self harm. Respondents are asked to consider each item in relation to '*individuals who deliberately or consciously engage in harming themselves by a variety of means, e.g. burning, cutting, self poisoning, but who are not considered to be making a direct attempt to kill themselves: an act with a non-fatal outcome*'. Participants must indicate agreement or disagreement with each statement on a seven point Likert scale ('strongly agree' to 'strongly disagree'). Patterson et al. (2007a) used three sources of data to construct the SHAS, and to establish its validity. These included a review of literature on attitudes towards suicidal behaviour; a series of focus groups and interviews with mental health staff and self harming clients, and consultation with an expert panel of clinicians and academics. Factor analysis conducted by the original authors revealed six subscales; (i) competence appraisal; (ii) care futility; (iii) client intent manipulation; (iv) acceptance and understanding; (v) rights and responsibilities; (vi) needs function (Appendix C).

To date, there have been four peer reviewed publications using the SHAS (Table 13). The validity of this scale is supported by these studies which have found high antipathy scores to be associated with years since registration and registration as a general vs mental health nurse, and lower antipathy associated with younger age, and education in self harm (Conlon & O'Tuathail, 2012; Dickinson & Hurley, 2012; Patterson et al., 2007a). In terms of reliability, the SHAS has shown high internal consistency (Chronbach's alpha = 0.89; Patterson et al., 2007a) and good test retest reliability (r = 0.98; Patterson et al., 2007b). However, the scale has some limitations. The initial factor analysis was conducted on a relatively small (n=153), self-selecting sample of nurses attending a number of post-registration educational courses, and so may not be reliable, in addition, previous studies using the SHAS have not included any further tests for internal consistency, nor reproducibility of the factor analysis. The authors suggest that antipathy scores should be examined amongst a random sample of staff, including unqualified staff and should explore the extent to which the attitude of individuals is reflected in a care team's overall attitudes. These issues are addressed in this research study. This was the largest study to adopt the SHAS, and so provides important data regarding the reliability of the scale.

There are currently two other Likert measures of staff attitudes towards self harm; the Attitudes Towards Deliberate Self harm Questionnaire (ADSHQ; McAllister et al., 2002) and a measure of staff attitudes towards self harm developed by Crawford, Geraghty, Street, and Simonoff (2003) (unnamed). The scale developed by Crawford et al. (2003) is a measure of staff attitudes towards young people who self harm, and so was not appropriate for use in this study. The ADSHQ has been used more frequently than the SHAS (Gagnon & Hasking, 2012; Hauck et al., 2013; Martin & Chapman, 2013; McAllister et al., 2002; McCarthy & Gijbels, 2010; Treloar, 2009), and was developed using a slightly larger sample (n=256). However, it is primarily designed for use with general nurses working in emergency departments, and so contains a number of items that would not be meaningful to a sample of mental health nursing staff, for example "*I feel that clients who self harm are treated less seriously by the medical staff than clients with medical problems*". The SHAS therefore is a more valid measure of mental health staff attitudes towards self harm. It also includes a number of items which ask about some of the underlying principles of a harm minimisation approach, which is of particular interest in this study.

Table 13. Summary of studies using the Self Harm Antipathy Scale

Study	**Sample**				
	Country	Setting	Occupation	Response rate	*n* (staff)
Patterson, Whittington, & Bogg, J (2007)	UK	Accident and Emergency, minor injuries, other general health care, forensic services, learning disabilities	Mental Health Nurses, General Nurses and Social Workers	Not reported	153
Dickinson, Wright, & Harrison (2009)	UK	Secure CAMHS and Young Offenders Institute	Mental Health Nurses, General Nurses and Nursing Assistants	40%	60
Dickinson & Hurley (2011)	UK	Young people's forensic services	Mental Health Nurses, General Nurses and Nursing Assistants	46%	47
Conlon & O'Tuathail. (2012)	Ireland	Accident and emergency	General Nurses	60%	87

3.4.6.3.4 The Attitude to Personality Disorder Questionnaire

Staff attitudes towards the general population of inpatient service users were measured using the Attitude to Personality Disorder Questionnaire (Bowers & Allan, 2006). This is a 35 item Likert scale which assesses staff's degree of enjoyment, security, acceptance, enthusiasm and sense of purpose in working with service users with a diagnosis of personality disorder. It has good test retest reliability (r= 0.8). Scores from this scale have been shown to be related to underlying beliefs and moral judgments about the negative behaviours of service users. Positive scores have been shown to be correlated with low staff stress, high performance (as judged by seniors), high interaction rates with service users, and more positive perceptions of management (Bowers, Carr-Walker, et al., 2006). For the purpose of this study, the questionnaire was adjusted to refer to 'patients on this ward', making the results more general (Appendix B).

3.4.6.3.5 The Short Form (36) Health Survey

The SF-36 is a 36 item scale designed to measure constructs of physical and mental health within both general and clinical populations (Ware Jr & Sherbourne, 1992). It assesses the status of eight concepts of health; 1) limitations in physical activities because of health problems; 2) limitations in social activities because of physical or emotional problems; 3) limitations in usual role activities because of physical health problems; 4) bodily pain; 5) general mental health (psychological distress and well-being); 6) limitations in usual role activities because of emotional problems; 7) vitality (energy and fatigue); and 8) general health perceptions. The SF-36 has been translated for use in over 50 countries and has become the most extensively validated and used instrument for measuring generic health status.

3.4.6.4 Procedures

Thirty-one wards were randomly selected to participate in the study from a list of all NHS hospitals with two or more adult acute wards in the South East of England. Research staff met with ward managers to provide information about the study and ask for their consent. Once consent was secured, the research team visited the wards regularly over a two week period to seek consent from ward staff. Data collection commenced once the majority (i.e. at least 50%) of staff, including the ward manager, provided signed consent. Data were collected for six weeks during the two month pre-implementation phase of the Safewards trial. Questionnaires were marked with a code unique to staff member, and were distributed to all nursing staff, with a blank envelope. If staff had not yet been asked for consent, a consent form and information sheet was added to their questionnaire pack.

Staff who had declined to participate were not given a questionnaire pack. Questionnaires were either returned direct to the researchers, or via a sealed box on each ward which was emptied at regular intervals by the research team.

3.4.6.4.1 Strategies to encourage participation

Studies using the SHAS report response rates ranging from 40%-60% (Table 13), however conducting research within psychiatric inpatient services can be particularly difficult as these services support people in crisis. Wards are often very busy, sometimes chaotic, environments and are frequently understaffed. Consequently, there is often resistance to research because of the demands on staff time. In addition, because wards are high risk environments, nursing practice is closely monitored, and so research can be met with defensiveness from staff who may feel that the research team are there to evaluate their practice (Brennan, Flood, & Bowers, 2006; Roach, Duxbury, Wright, Bradley, & Neil, 2009). This resistance to research was evident during the pilot study, where just 48% of consented staff completed a questionnaire pack. To improve engagement during the main trial, the following strategies were employed:

1. Researchers met with the ward manager and senior staff team before the start of recruitment.
2. During the recruitment phase, researchers spent as much time as possible on the wards, to build relationships with staff and address any concerns they had about the study.
3. The researcher continued to maintain a presence on the ward, during the data collection phase, visiting each ward at least twice a week.
4. The time period for data collection was extended from 4 to 6 weeks.
5. Staff were sent regular reminders to complete their questionnaires via email, and posters were displayed in the staff office.
6. Staff were offered a £5 gift voucher if they completed a questionnaire pack

3.4.6.5 Data Management

Data were entered onto computer using Snap survey optical mark recognition software, and copied to STATA version 11 for analysis. To ensure accuracy of the data, all electronic data were checked against the original questionnaires. Hard copies of the questionnaires were stored in a locked filing cabinet, and all electronic data stored in a password protected folder.

3.4.6.6 Statistical Analysis and Treatment of Variables

3.4.6.6.1 Missing data

Missing data are common in self report survey studies and occur when a participant completes some, but not all, items on the questionnaire (item non response). There are several ways to handle missing data. One approach is to delete any cases with missing values, however this will decrease the sample size and so reduce statistical power. The missing values may also introduce bias where they are not missing at random (MAR), i.e. if the missing data can be predicted from other variables in the dataset. It is therefore only advisable to delete cases with missing data where the data are missing completely at random (MCAR). MAR values can be estimated using the available dataset and the inputted values included in the analysis. Multiple imputation (MI) is currently considered the most appropriate technique for imputing missing values for MAR data (Tabachnick & Fidell, 2005), however the process produces a large number of datasets meaning that analysis is complex and time consuming (Rubin, 2004). Alternatively, one of the most widely used methods of imputation is mean substitution (MS), however this method can distort the distribution of the data and reduces correlations between variables (Tabachnick & Fidell, 2005). For this study, a missing data analysis of dependent variables (SHAS data) was conducted according to the guidelines outlined by Hair, Tatham, Anderson, and Black (2006). Cases with large amounts of missing data (over 30%) were deleted. Following this, a sensitivity analysis was conducted, comparing an MI dataset, an MS dataset, and a dataset where there had been no treatment of missing values (see section 5.2). Because there were no major differences in total self harm score and sub scores between imputation methods, the MS dataset was used during data analysis.

3.4.6.6.2 Statistics

Descriptive and inferential statistics were used to answer the research questions (Table 14). In addition, an exploratory factor analysis of SHAS scores was performed to determine if the factors underlying antipathy identified by Patterson et al. (2007a) were consistent in this larger randomly selected sample of staff.

Table 14. Statistical tests employed to answer the research questions during Phase I

Research Question	Variables	Analyses.
Is the structure of the SHAS identified by Patterson et al., stable across populations of inpatient staff?	SHAS and sub scores	Conformatory and Exploratory factor analyses
What are the attitudes of nursing staff towards people who self ham?	SHAS (total score)	Descriptive statistics
What are staff views of harm minimisation practices?	SHAS (questions 2 and 8)	Descriptive statistics
Are attitudes towards self harm a property of teams, or individuals?	SHAS, ward ID	Analysis of variance
How are attitudes towards people who self harm related to staff characteristics and wellbeing?	SHAS, SF-36, basic staff data	Multiple regression
How do staff's perceptions of service users who self harm relate to their view of service users in general?	SHAS and APDQ	Bi-variate correlation

Before any statistical tests were employed, the data were tested for compliance with the assumptions of multivariate analysis (Tabachnick & Fidell, 2005). Variables were checked for skewedness (skewness > .2) and standardised scores (z scores) were examined to identify any potential outliers. No variables were skewed, and no outliers were identified. Procedures for multivariate analyses conducted in relation to questions one and five are outlined below

3.4.6.6.3 Q1: Is the structure of the SHAS identified by Patterson et al., stable across populations of inpatient staff?

The reliability of the Self Harm Antipathy Scale (SHAS), and its proposed factor structure were assessed using the following techniques:

3.4.6.6.3.1 Internal consistency

Internal consistency of the SHAS and subscales were assessed using item-rest correlations, and Chronbach's α (alpha). Item-rest correlations are a measure of the correlation of each scale item to the total scale, minus that item. Item rest correlations are thought to give a better estimate of item fit than the more commonly used item-test correlations (correlation between the item, and the scale including that item) because items with a poor fit may distort the scale (Nunnally, Bernstein, & Berge, 1967).

Acceptable levels of item-rest correlations are >0.2 for the whole scale (Kline, 1986), and >0.5 for subscales (Robinson, Shaver, & Wrightsman, 1991). Chronbach's α is a reliability coefficient which assesses interitem correlations for all pairs of items in a scale. In general, values of above 0.7 are thought to indicate good reliability, however values of above 0.6 are considered acceptable in exploratory research (Hair et al., 2006).

3.4.6.6.3.2 Confirmatory Factor Analysis

A confirmatory factor analysis (CFA), using maximum likelihood estimation in AMOS 21, was conducted to test if the hypothesised factor structure of the SHAS identified by Patterson et al. (2007a), is stable across all nursing staff populations. During CFA the hypothesised model is used to estimate a covariance matrix, which is then compared with the observed covariance matrix. The validity of the proposed factor structure is demonstrated by acceptable levels of model fit and evidence of convergent and discriminant validity (Hair et al., 2006).

3.4.6.6.3.3 Exploratory factor analyses

Exploratory factor analyses (EFA) is a statistical technique used to examine the underlying structure of a dataset by identifying a number of common factors that account for correlations among the set of variables. Common factors are thought to represent latent constructs that underlie the relationship between a set of observed variables (Pedhazur & Schmelkin, 2013). EFA therefore allows researchers to develop theory about the constructs that make up their data. Before conducting EFA bivariate and partial correlation matrices were examined to ensure there were sufficient correlations in the data to justify use of a factor analyses (Tabachnick & Fidell, 2005). Factors were extracted with maximum likelihood extraction estimates using SPSS Version 18.0. Selection of the number of factors to be extracted was based on eigenvalues greater than or equal to one (Tabachnick & Fidell, 2005). Oblique promax rotation of factor loadings was used, since the factors were found to be correlated (Fabrigar et al, 1999). Internal consistency of the factors was determined using Chronbach's α.

3.4.6.6.4 Q5. How are attitudes towards people who self harm related to staff characteristics and wellbeing?

The relationships between staff characteristics and attitude towards self harm were investigated using multiple regression. Firstly, subscales were screened for outliers and skeweness to ensure the data met the assumptions of multivariate analysis (Tabachnick & Fidell, 2005). Values for skewness were all >0.2, and one outlier was deleted. Covariates were selected for inclusion in the regression based on univariate analyses

(Independent samples t-test and ANOVA). This was because inclusion of irrelevant variables can reduce model parsimony, and mask the effects of more influential variables (Hair et al., 2006). Variables found to be significant at the 0.01 level were entered into a multivariate linear regression model to estimate adjusted effects. The regression controlled for clustering at the ward level using the Huber-White procedure (Huber, 1967). Backward stepwise elimination was used to drop non-significant variables from the model at the 0.05 significance level. Mullticollinearty was assessed using the Variance Inflation Factor (VIF), which measures the extent to which a regression coefficient is increased due to collinearity.

3.4.7 Phase II

3.4.7.1 Approach

Semi structured interviews were used to provide in depth data regarding inpatient nursing staff's perceptions of service users who self harm. This format of interview was selected primarily because it enabled the student to cover additional topics of interest (staff views of harm minimisation practices, and definition of self harm), whilst also allowing her to be flexible in her responses, (e.g. to use follow up questions, or to ask for clarification), in order to obtain a detailed account from participants (Robson, 2002). There are a wide range of methodologies that can be used to analyse interview data. These include Interpretive Phenomenological Analysis (IPA; Oldershaw, Richards, Simic, & Schmidt, 2008), Grounded Theory (Anderson, Standen, & Noon, 2003), Discourse Analysis (Horsfall & Cleary, 2000), and Ethnomethodology (Baker, 2001). Each draw on a different aspect of social theory; for example, discourse analysis focuses on the way in which an individual presents their social world through talk, and is based on the constructionist theory that language does not represent a definitive version of reality, or 'truth', but instead is used to create an identity, or perspective to fit the context in which it is produced. As outlined in section 3.2, this study adopted a pragmatic approach, which does not favour one form of social reality over all others, and instead, is concerned with selecting the most appropriate method to answer the research question. The chosen method of analysis for this study was thematic analysis. Thematic analysis is described as 'a method for identifying, analysing and reporting patterns (themes) within data' (Braun & Clarke, 2006). Unlike other qualitative methodologies, such as grounded theory or IPA, which comprise a specific set of procedures applied to a single topic of interest, thematic analysis is a flexible approach which can be used across a range of research topics (Braun & Clarke, 2006). It is therefore well suited to the interview data produced in this study, which covers both staff perceptions of self harm, and also their views of

harm minimisation practices. Thematic analysis forms the foundation of many forms of qualitative analysis, but is now also considered a methodology in its own right, and, because it draws directly from the data, is arguably one of the most systematic and transparent methods of analysis (Joffe, 2011).

3.4.7.2 Sample

Participants were selected for participation in Phase II on the basis of their antipathy scores collected during Phase I. To provide the most rich and contrasting examples of staff perceptions of self harm, a purposeful, extreme group sampling strategy was employed (Patton, 1990). This approach does not select cases intended to be representative of the sample as a whole, but those that represent the most intense examples of a phenomenon of interest. Inclusion criteria were the following:

1. Permanent nursing staff (qualified nurses and nursing assistants)
2. Consented to participate in the Safewards trial
3. Working on wards in the control arm of the trial
4. With antipathy scores that fell within the top or bottom 10th percentile of scores collected during Phase I

Because interviews were conducted at the end of the Safewards trial, and the Safewards intervention may have had some impact on attitude, staff were sampled from wards participating in the control arm only. A t-test was conducted to compare mean attitude scores between staff in each arm of the trial, and no significant differences were found at the pre-implementation phase (Mean SHAS score; control = 80.6, intervention = 80.7, $p = 0.95$). A random sample of 10 staff from the bottom, and 10 from the top, 10th percentile of antipathy scores collected during Phase I were selected. A sample of 20 staff was chosen as it exceeded the recommended minimum number of participants for an interview study (Guest, Bunce, & Johnson, 2006), and was also thought to be an achievable number, given the challenges of engaging inpatient nursing staff in research (see section 3.4.6.4.1 for a discussion of these issues).

3.4.7.3 Tools

Interviews were guided by a schedule of questions which ensured that all topics of interest were covered during the interview, and also meant that interviews were similar in their structure and content to aid comparison between transcripts (Appendix D). The structure and wording of the interview schedule addressed the research questions, whilst also ensuring that participants remained engaged and were able to provide in depth answers to the interview questions. For example, questions were worded clearly using

neutral language, and were open ended. The schedule was kept as short as possible, and the more controversial topics (e.g. harm minimisation) were left till the end of the interview (Turner, 2010). To ensure that the questions were clear and elicited the desired information, the schedule was discussed at a departmental research meeting and was piloted in two interviews with qualified nurses working on two acute wards in East London. Q6 on the pilot schedule was amended because the staff had not heard of harm minimisation practices before (Additions highlighted in Appendix D).

3.4.7.4 Procedures

Interviews took place at the end of the Safewards trial, 4 months after data collection for Phase I. The trial researchers assisted with the initial phase of recruitment following a brief training session with the student, who gave an outline of the study and procedures for recruitment. Participants were randomly selected from a list of eligible nursing staff. Research assistants then met with their ward managers to provide information about this phase of the study. The research assistants sent participants an email including information about the study and an invitation to participate. If there was no response, the student followed this up with a phone call. If the staff member declined to participate, another was randomly selected from the list of eligible staff. This process was repeated until the target sample was recruited. As discussed in section 3.4.6.4.1, to encourage participation and as a recognition for participant's time and contribution to the study, staff were offered a £5 voucher if they completed in an interview. Interviews were conducted in a meeting room on the ward or within the hospital, and were recorded using an Olympus WS-320M digital voice recorder.

3.4.7.5 Data management

All interviews were transcribed verbatim and the transcripts anonymised (i.e. any identifiable information such as names of people, or wards were removed). Transcriptions and recordings were assigned a research number and stored in a password protected folder.

3.4.8 Analysis

Interviews were analysed using thematic analysis. The analysis aimed to provide a detailed account of themes related to the research questions, rather than a representation of the entire dataset (Braun & Clarke, 2006). For this study, a 'theme' constituted a pattern of meaning which was either directly observable in the data (explicit content), or seen to be underlying what was said in the data (manifest content) (Joffe,

2011). Analysis was grounded in the data, but was also guided by previous research into staff attitudes and self harm. Data analysis followed the six stage process outlined by Braun and Clarke (2006; Table 15).

Table 15. Phases of thematic analysis (Braun & Clarke, 2006, p. 87)

Phase	Description of the process
1. Familiarising yourself with the data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme
4. Reviewing themes:	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

3.4.9 Validity and reliability

Because of the interpretative nature of qualitative research it is generally accepted that the criteria used to assess the quality of quantitative research cannot be directly applied to qualitative studies (Bryman, 2012). Braun and Clarke (2006), have outlined 15 criteria necessary to achieve a robust thematic analysis (Appendix E), and the analysis was conducted according to these criteria. There are currently a number of different approaches to addressing issues of validity and reliability qualitative research (Hammersley, 1990; Mays & Pope, 2000; Seale, 1999; Shenton, 2004; Silverman, 2011), and criteria against which quality is judged is often determined by the epistemological assumptions guiding the data analysis (Seale, Gobo, Gubrium, & Silverman, 2004). In this case, additional measures taken to ensure the validity and reliability of the analysis were:

a. **Random sampling of participants:** Which helped to prevent researcher bias in the selection of staff, and ensured a more representative sample (Shenton, 2004).

b. **Account of reflexivity:** Reflexivity is an awareness of the researcher's effect on the processes and outcomes of a research study. A detailed account of how the student's views and experiences may have shaped the analysis is provided (Appendix F), to enhance the credibility of the research findings (Mays & Pope, 2000)
c. **Peer review of the thematic analysis:** The analysis was reviewed regularly during supervision, to ensure that the student's interpretation was an accurate reflection of the meaning in the data (Shenton, 2004).
d. **Ensuring plausibility:** Research findings are seen to be plausible if they are consistent with theories accepted by the scientific community (Hammersley, 1990). To ensure the findings were plausible, the analysis was guided by previous research into staff attitudes towards people who self harm.
e. **Triangulation:** Triangulation is the cross verification of results using two or more sources of data (Seale, 1999). This study collected both survey and interview data, and triangulation of the findings are outlined in section 7.3.

4. Results: Study 1

This chapter presents the results of Study 1. As described in section 3.3, Study 1 was a cross-sectional, documentary analysis of incident reports of self harm, collected by the National Patient Safety Agency (NPSA). The results of the analysis are presented here in the following order:

1. Description of incident reports
2. Demographic characteristics and type of admission
3. Type of service

And then according to the research questions outlined in section 3.4.2 as follows:

4. What are the characteristics of self harm within inpatient psychiatry, as documented in incident reports of self harm?
5. What are the antecedents to self harm?
6. What interventions are used following self harm?

4.1 Description of incident reports

As outlined in section 3.3.4, a random sample of 500 reports were selected from all reports of self harm collected by the NPSA during 2011. Fifty two did not meet the inclusion criteria (section 3.3.4) for the following reasons: threats of but not actual self harm (n=33), substance misuse (n=15), self harm which took place outside of the ward (n=3) and suicide (n=1). This left a total of 448 cases for analysis.

Reports included the following fields of information; date of incident, time of incident, age at time of incident, care setting of occurrence, gender, ethnicity, description of what happened and ward staff rating of the severity of the act. As described in section 3.3.6.1, a content analysis of the free text field 'description of what happened' was conducted to obtain further information about the episode of self harm. This data was coded into the following categories: location of the incident on the ward, method of self harm, objects used, antecedents to self harm, containment measures in place at time of self harm, and staff interventions following self harm.

There was substantial variation in the amount of information provided in reports, which ranged from one line, to over 350 words in length. Most reports provided basic demographic information, and detailed the location, time and method of self harm. Other useful information, for example information about the antecedents to self harm, or the response of nursing staff, was often not provided.

4.2 Demographic characteristics and type of admission

Almost three times as many episodes of self harm were by women (n = 292, 65%) rather than men (n=106, 24%). In 11% of reports (n=50) the gender of the individual was not specified. The mean age was 35 years (s.d = 13.7), and ranged from 18 to 93. People from a white ethnic background featured in just over half of reports (n = 249, 56%), 6% of incidents involved people from a minority ethnic background (n=25), and the ethnicity of people involved in 39% of incidents (n=174), was not specified. With respect to legal status, there was a lot of missing data (n=195, 44%), or cases where legal status was unknown (n=143, 31.9%). In 20.3% of cases (n=91) the person was detained under the mental health act, in 4.2% of cases (n=19) they were not detained.

4.3 Type of service

Sixty five percent of incidents (n=289) took place within acute services, 29% (n=130) within forensic services, 5% (n=21) within older adult, and 2% (n=8) within mental health rehabilitation services. Taking into account the numbers of beds within each service nationally (The NHS Information Centre, 2009), there were significantly more reports of self harm on forensic wards compared to other types of wards (Table 16, z= 11.22, p<0.001). The odds of a forensic ward reporting an incident of self harm were three times greater than for acute wards (OR = 3.01, 95%, CI = 2.31-3.91).

4.3.1 Differences in characteristics of self harm by type of service

Lethality scores were significantly higher within acute services than other types of services (2.36 vs 1.86, U = 9177, z = -2.29, p = 0.02). Fisher's Exact Test revealed differences in the types of self harm occurring within different inpatient services. Because of low numbers of reports from older adult, and mental health rehabilitation services, this analysis was conducted for forensic and acute wards only. Within acute services, there were more episodes of self poisoning (11.9% vs 2.3%, p < 0.01), and restricting breathing (24.5% vs 14.7%, p = 0.02). Whilst on forensic wards, outwardly aggressive forms of self harm (8.4% vs 26.4%, p < 0.001) and 'other' forms of self harm (6.6% vs 17.8%, p = 0.001) were more common.

Table 16. Rate of self harm per 100 bed days.

Type of ward	Rate/100 occupied bed days†
Adult mental health	2.54
Forensic mental health	4.12
Mental health rehabilitation	0.28
Older adult	0.23

†The sum of all the days that patients in the group occupied hospital beds during the Hospital Episode Statistics (HES) year

4.4 What are the characteristics of self harm within inpatient psychiatry, as documented in incident reports of self harm?

4.4.1 Method

Over twenty different methods of self harm were described, these were grouped into different forms of self harm, which had similar characteristics (Table 17) using the process described in section 3.3.6.1. People most often self harmed by breaking the skin (n=174, 38.8%), this was followed by restricting breathing (n=90, 20.1%), outwardly aggressive methods (acts of self harm which were more overly aggressive), such as head banging/punching (n=65, 14.5%), and self poisoning (n= 40, 8.9%). 'Other' methods used were insertion of foreign objects (3.1%, n=14), burning (2.2%, n=10), ingestion of foreign objects (1.1%, n=5), biting (0.9%, n=4), friction burns (0.9%, n=4), jumping or falling (0.7%, n=3), drowning (0.4%, n=2), collision with automobile (0.2%, n=1), removing part of a fingernail (0.2%, n=1), and pulling hair (0.2%, n=1).

Table 17. Method of self harm

Method	*n*	*%*
Breaking skin	174	38.8
Restricting breathing	90	20.1
Outwardly aggressive	65	14.5
Self poisoning	40	8.9
Other	45	10.0

There were significant differences in the methods of self harm used by men and women; a higher proportion of men used outwardly aggressive methods of self harm (12.6% vs

1.4%, χ^2 = 23.11, n = 392, d.f = 1, p=< 0.001), whilst women were more likely to use methods of restricting their breathing (11.7% vs 23.2%, χ^2 = 6.28, n = 392, d.f = 1, p<0.01). Of those who used methods of strangulation, men were more likely to attach a ligature to a ligature point, whilst women were more likely to self ligature (86.6% vs 13.4%, χ^2 = 12.70, n = 79, d.f = 1, p<0.001).

Table 18. Method of self harm by gender

Method	**Female** ***(%)***	**Male** ***(%)***
Breaking the skin	41.2	32.0
Outwardly aggressive methods	11.1	29.1
Restricting breathing	23.2	11.7
Self poisoning	9.0	8.7
Duplicate methods	5.9	6.8
Other	9.7	11.7

4.4.2 Severity

As discussed in section 3.3.6, the severity of injuries sustained following the act of self harm was assessed using the staff rating of severity, which was provided in all reports. The lethality of the method used was not provided in reports, and was determined using the Lethality of Suicide Attempt Rating Scale (Smith et al., 1984).

Staff ratings of severity indicated that in 30% (n=134) of incidents there was ‘no harm’ to the individual, 60% of incidents were reported as ‘low harm’ (n=268), 10% (n=45) as ‘moderate harm’ and 0.2% (n=1) ‘severe harm’. In 8% of cases (n=34) it was reported that the service user had attended an accident and emergency department for treatment.

The mean lethality score was 2.1 (s.d = 2.17). Most incidents were low lethality (68%, n = 303), with scores ranging from 0-3.5, 7% were high lethality (n = 31), with scores ranging from 5-9. The lethality of 114 incidents (25%) could not be determined because there was not enough information provided in the report, for example, no indication of how deeply someone had cut, or the type of medication they had taken. Differences in lethality score by method were examined using one way ANOVA, which

revealed a significant main effect (F(5, 314) = 1.82, p<0.001), with methods of restricting breathing having the highest lethality scores, and methods of breaking the skin, and 'other' methods of self harm the lowest (Table 19). There was no significant correlation between age and lethality score (r = -.066, p = 0.27), nor differences in lethality score between genders (mean female = 2.16, mean male = 2.17, U = 8949, z = -0.11, p = 9.1).

Table 19. Lethality score by method of self harm

Method	*n*	*mean*	*min*	*max*	*SD*
Restricting breathing	64	4.8	0	9	3.1
Duplicate methods	15	2.4	0	7	1.9
Outwardly aggressive methods	45	2.1	0	3.5	1.2
Self poisoning	27	1.9	1	3.5	1.2
Breaking the skin	137	1.3	0	5	1.1
Other	43	1.1	0	3.5	0.8

4.4.3 Objects used

In total, 141 different objects were used for self harm. Most frequently doors, walls or windows for head banging or hitting (n=97, 21.7%), followed by clothing or underwear (n=39, 8.7%), razors (n=39, 8.7%), kitchenware (n=38, 8.5%), medication (n=35, 7.8%), stationary (n=4.5, 2.0%), electrical cables (n=9, 2.0%), plastic bags (n=7, 1.6%), bed linen (n=6, 1.3%), and other poisons (n=3, 0.7%). In most episodes of strangulation (71.0%, n=88) people did not use a ligature point (self ligature). In 17 cases people tied ligatures to a ligature point, and used bathroom or bedroom doors (n=5), bathroom pipes or rails (n=4), beds (n=3), curtain rails (n=2), shower door (n=1), shower head (n=1), and a sink (n=1).

4.4.4 Openness: A measure of the social nature of self harming behaviour

Openness scores were low. Most people self harmed in private (score= 0, n = 144, 32.1%), or self harmed in private, and then reported the incident to staff (score= 1, n = 112, 25.0%). Smaller numbers of people self harmed in public areas, but not in front of others (score= 2, n = 34, 7.6%), or self harmed in front of staff (score= 3, n = 32, 7.1%). A number of people self harmed in a very public way, in communal areas, overtly displaying self harm by gesturing, or making loud noises (score= 4, n = 31, 6.9%). A Kruskal Wallis test revealed significant differences in the openness score by method of

self harm ($\chi^2(2) = 115.65$, d.f = 5, p< 0.001). Those who used outwardly aggressive methods had the highest openness scores (mean= 2.4, s.d = 1.4), followed by duplicate methods (mean= 2.4, s.d =1.4), self poisoning (mean= 1.2, s.d. = 1.0), and methods of breaking the skin (mean= 0.8, s.d. = 1.0). Methods of restricting breathing had the lowest openness scores (mean= 0.3, s.d = 0.7). Men had significantly higher openness scores than women (1.0 vs 1.5, U = 7125, z = -2.97, p < 0.01), there were no significant differences in openness score for any other demographic variable.

Table 20. Mean openness score by method of self harm

Method	*n*	*mean*	*min*	*max*	*SD*
Outwardly aggressive methods	49	2.4	0	4	1.4
Other	34	1.8	0	4	1.2
Duplicate methods	20	1.8	0	4	1.4
Self poisoning	32	1.2	0	4	1.0
Breaking the skin	123	0.8	0	4	1.0
Restricting breathing	72	0.3	0	4	0.6

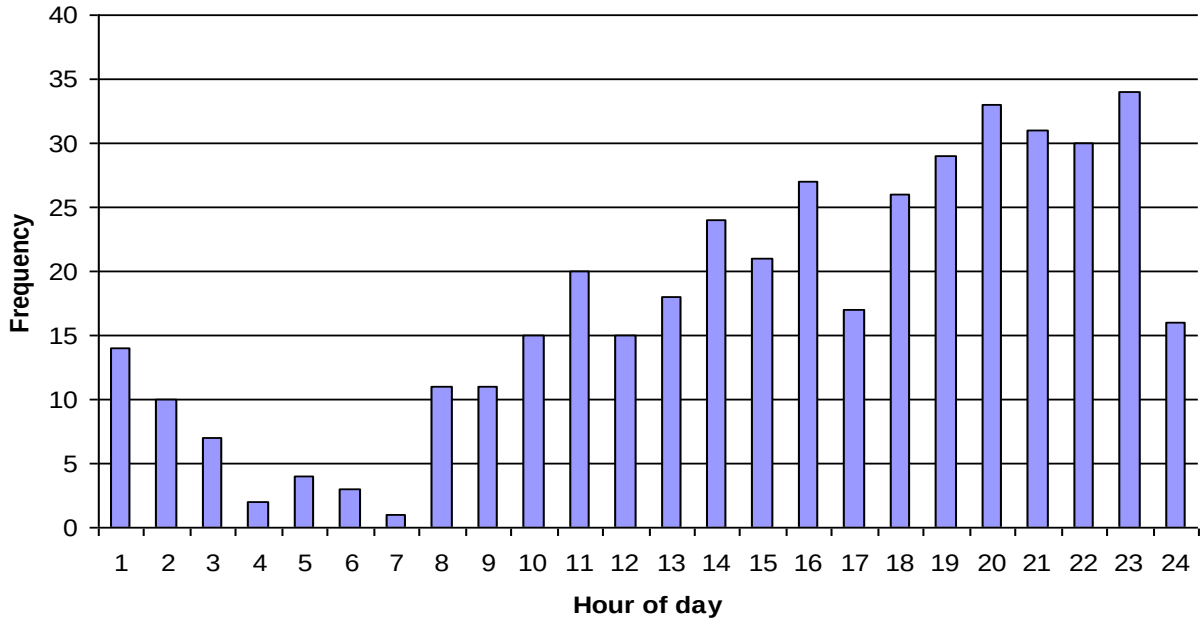
4.4.5 Location

Most episodes of self harm took place in the private areas of the ward, such as bedrooms (n=94, 21.0%) or bathroom/shower rooms (n=41, 9.2%). A number of episodes took place in the toilet (n=19, 4.2%), seclusion room (n=16, 3.6%), outside of the ward (n=12, 2.7%), and ward outside areas (n=10, 2.2%). A smaller number of incidents took place in more public areas on the ward such as unspecified communal areas (n=5, 1.1%), kitchens (n=3, 0.7%), corridors (n=3, 0.7%), dining rooms (n=2, 0.4%), day areas (n=4, 0.9%), and living rooms (n=1, 0.2%).

4.4.6 Timing

Chi Square test of goodness of fit was performed to determine if the incidence of self harm throughout the day was equally distributed. A significantly higher proportion of suicide attempts occurred in the evening hours ($\chi^2 = 136.90$, n = 419, d.f = 23, p=< 0.001) with the highest number of attempts occurring between 20:00 and 23:00. There were no significant differences in the number of attempts occurring on each day of the week, or for each month of the year.

Figure 1. Frequency of self harm by hour of the day



4.5 What are the antecedents to self harm?

The antecedents to self harm were described in just 24% of reports (n=106), and are shown in Table 21. Staff most often gave accounts of people self harming after experiencing difficult emotions, or hearing voices (internal experiences), or following some form of conflict behaviour (behaviours which threatened staff, or service user safety). This was most frequently previous self harm, verbal aggression or substance misuse. Conflict with staff was also a common antecedent, this was mainly related to issues around service user or staff requests.

Table 21. Antecedents to self harm

Antecedent	*n*	Description
Internal experiences	54	General but overt description of change in mood (e.g. was angry, low, depressed, or hearing voices)
Conflict behaviours	39	Verbal or physical aggression, absconding, rule breaking, substance misuse, self harm
Conflict with staff	22	Disagreements, arguments or descriptions of the person being upset/angry with staff
Containment	9	Observation, seclusion, time out, restraint, Pro Re Nata or Intra Muscular medication
External factors	9	Issues outside of the ward environment (e.g. relationship or housing problems)
Entering or leaving ward	7	Descriptions of person entering or leaving the ward (e.g. came back from/went on leave)
Ward community	6	Issues with the ward community (e.g. arguments with other service users, noise, other incidents)
Other	13	All other antecedents

4.6 What nursing interventions are used following self harm?

4.6.1 Containment at time of self harm

In eighty one cases (18%), it was reported that people were under some form of containment when they self harmed. This was most frequently intermittent (n = 31), constant (n = 20), or unspecified (n = 11) levels of special observation. Other forms of containment were seclusion (n = 16), time out (n=1) and the use of CCTV (n = 1) or contracts to stay out of the bedroom (n =1).

4.6.2 Interventions following self harm

The interventions used following self harm were specified in 129 cases (29%). Most frequently used was verbal de-escalation, which consisted some form of supportive verbal communication between service user and staff. This included exploring more positive coping strategies, providing reassurance, and offering the service user time to talk about their feelings. In 31 cases (6.9%) the service user was restrained, and in 19 cases (4.2%) levels of special observation were initiated. Other interventions used were Pro Re Nata (PRN) medication (n= 18, 4.0%), search of service user's room (n = 17, 3.8%), Intra Muscular (IM) medication (n = 13, 2.9%), time out (n = 7, 1.6%), offering

PRN (n = 7, 1.6%), transfer to another ward (n = 6, 1.3%), moving service user to a communal area (n = 6, 1.3%), and seclusion (n = 5, 1.1%). A significantly higher proportion of men than women were given PRN medication following self harm (7.5% vs 2.5%, $p < 0.05$, Fishers Exact Test), there were no other significant differences in intervention by demographic variable.

4.7 Summary of findings

Study 1 was limited by the varying amount of information provided in incident reports. Some reports were very detailed, many however were brief and omitted useful information, particularly regarding the circumstances of, and nursing responses to self harm.

Reports featured over twenty different methods of self harm. Most common were methods of breaking the skin, followed by restricting breathing, and outwardly aggressive methods such as head banging or hitting. Self harm was mostly a very private act, which often took place in bedrooms, or bathrooms, and during the evening hours. Openness scores for self harm were low. Self harm was more common within forensic services, and people within forensic services were more likely to self harm using outwardly aggressive methods, whilst those within acute services were more likely to self harm by self poisoning, or restricting their breathing. There were also differences in self harming behaviour by gender; most episodes were by women, and whist women were more likely to restrict their breathing, men were more likely to use outwardly aggressive methods of self harm. There were, however, no significant differences in lethality scores between men and women. One hundred and forty one different objects were used for self harm. Most frequently objects that it would be difficult to restrict access to, e.g. doors, walls or windows for head banging or hitting, followed by clothing or underwear. The majority of episodes of self harm were low lethality, and resulted in ‘low’ levels of harm to the individual.

5. Results: Study 2, Phase I

This chapter presents the results of Phase I of Study 2. As described in section 3.4, Study 2 was a sequential explanatory study of attitudes towards self harm amongst inpatient nursing staff, and as such, comprised of two phases:

> Phase I: a survey of staff attitudes towards people who self harm, using the Self Harm Antipathy Scale (Patterson et al., 2007a)
>
> Phase II: semi structured qualitative interviews exploring staff perceptions of self harm.

Staff were selected for participation in Phase II based on their attitude scores obtained during Phase I. This chapter presents the analyses of SHAS data collected during Phase I. A description of the selection of participants for Phase II, and the analyses of Phase II interview data are reported in Chapter 6.

The results of the analysis of Phase I SHAS survey data are presented here in the following order:

1. Description of sample size and response rate
2. Missing data analysis
3. Description of sample characteristics

And then according to the research questions outlined in section 3.4.2 as follows:

4. Is the structure of the SHAS identified by Patterson et al., stable across populations of inpatient staff?
5. What are the attitudes of nursing staff towards people who self harm?
6. What are staff views of harm minimisation practices?
7. How do staff's perceptions of service users who self harm relate to their view of service users in general?
8. Are attitudes towards self harm a property of teams, or individuals?
9. How are attitudes towards people who self harm related to staff characteristics and wellbeing?

5.1 Sample size and response rate

For Phase I, the sample constituted all nursing staff working on wards participating in the Safewards trial (a full description of the trial can be found in section 3.4.4). Fifteen hospitals were recruited to take part in the Safewards trial and two wards were recruited from each hospital. There was, however, possibility of a ward closure in one hospital, so three wards were recruited and remained in the trial until the end, giving a total of 31 wards. Six hundred and thirty staff met the criteria for inclusion in this phase of the study, 544 (86.3%) consented to participate, of which 395 completed questionnaires, giving a response rate of 62.6%. After removing cases with large amounts of missing data (see section 3.4.6.6.1), the final sample size for analysis was 387; a ratio of 12.9 participants per SHAS item. This is above the recommended sample size for the exploratory factor analysis and regression presented in sections 5.4.3 and 5.9 respectively (Tabachnick & Fidell, 2005).

5.2 Missing data

A missing data analysis of dependent variables (SHAS data) was conducted according to the guidelines outlined by Hair et al. (2006). Missing data were tabulated by case and variable to assess frequencies and patterns. Eight cases with large amounts of missing data (over 30%) were deleted. Of the remaining 387 cases, the frequency of missing data ranged from one (13.1%, n=51), to seven (n=1, 0.2%) data points per participant, however the majority (80.3%, n= 311), had no missing values. All but one of the 30 variables had small amounts of missing data, ranging from 0.3% (n=3) to 2.1% (n=8) of the total possible observations. Little's MCAR test indicated that data were not missing completely at random (MCAR; X^2 = 1594.1, df = 1377, p<0.001). Logistic regression indicated that missing data could be predicted by ethnicity (β = .36, p = 0.02), and so the data were inferred to be missing at random (MAR); data is said to be MAR where missingness can be predicted by another variable in the dataset (Tabachnick & Fidell, 2005). As discussed in section 5.2 there are several approaches to dealing with missing data. Multiple imputation (MI) is currently considered the most appropriate technique for imputing missing values for MAR data (Tabachnick & Fidell, 2005), however produces a large number of datasets, and so analysis is more complex and time consuming (Rubin, 2004). One of the most widely used methods of imputation is mean substitution (MS) however this method can distort the distribution of the data and reduces correlations between variables (Tabachnick & Fidell, 2005). To determine the impact of imputation method on the data, a sensitivity analysis was conducted, comparing an MI dataset, an MS dataset, and a dataset where there had been no treatment of missing values (NM).

There were no major differences in total self harm score and subscores between imputation methods (Table 22). Regression analyses outlined in section 3.4.6.6 were conducted on all datasets, and revealed no meaningful differences in outcome. Consequently the mean substituted dataset was used for all further analyses.

Table 22. Comparison of mean total SHAS scores and subscores for datasets where missing data had been replaced with mean substituted (MS) and Multiple Imputed (MI) scores, and a dataset with no treatment of missing data (NM)

	n (MS/MI)	MS	MI	*n* (NM)	NM
Total score	387	80.74	80.82	308	80.02
Competence appraisal	387	2.20	2.21	363	2.19
Care futility	387	2.29	2.29	369	2.28
Client intent manipulation	387	3.13	3.13	369	3.11
Acceptance and understanding	387	2.33	2.34	372	2.32
Rights and responsibilities	387	4.01	4.02	365	4.00

5.3 Sample Characteristics

5.3.1 Ward characteristics

Wards were situated within nine NHS trusts, in the Southeast of England; 23 were in London, with the remainder in Essex, Hertfordshire and Surrey (Table 23). There were, on average, 19 beds per ward (range 8-28, s.d=4). Most were acute wards, and just over half served both women and men.

Table 23. Ward characteristics

	n	*%*
Location		
Inner London	10	32.3
Outer London	13	41.9
Essex	4	12.9
Hertfordshire	2	6.5
Surrey	2	6.5
Function		
Acute	21	67.7
Triage	6	19.4
PICU	4	12.9
Gender		
Female	10	32.3
Male	5	16.1
Mixed	16	51.6

5.3.2 Staff characteristics

Staff characteristics are displayed in Table 24. The majority of staff were female, aged between 30-59 and of African ethnic background. Most were nurses, and had been in post for over five years. This was an experienced group of staff, with more than three quarters of the sample having worked in mental health for over five years.

Table 24. Characteristics of the sample

	n	%
Age		
20-29	46	11.9
30-39	78	20.2
40-49	123	31.8
50-59	107	27.6
60 or over	10	2.6
Gender		
Male	152	39.3
Female	221	57.1
Ethnicity		
White	106	27.4
Irish	9	2.3
Caribbean	29	7.5
African	165	42.6
Asian	15	3.9
Other	48	12.4
Time in post		
1 year or less	59	15.2
1 to 3 years	94	24.3
3 to 5 years	47	12.1
More than 5 years	168	43.4
Time in mental health		
1 year or less	14	3.6
1 to 3 years	27	7.0
3 to 5 years	48	12.4
More than 5 years	283	73.1
Occupation		
Nurse	239	61.8
Healthcare Assistant	118	30.5
Occupational Therapist	8	2.1
Other	8	2.1

5.4 Is the structure of the SHAS identified by Patterson et al., stable across populations of inpatient staff?

5.4.1 Internal Consistency

Internal consistency of the SHAS and subscales were assessed using Chronbach's α (alpha). Chronbach's α is a reliability coefficient which assesses inter-item correlations for all pairs of items in a scale. In general, values of above 0.7 are thought to indicate good reliability, however values of above 0.6 may be acceptable in exploratory research (Hair et al., 2006).

Alpha values are displayed in Table 25. Values for the total scale, and Competence Appraisal, Care Futility and Client Intent Manipulation subscales all indicated good levels of internal consistency ($\alpha > 0.7$), the Rights and Responsibilities subscale demonstrated an acceptable alpha level, however the subscales Needs Function and Acceptance and Understanding subscales had poor internal consistency ($\alpha > 0.6$).

Table 25. Chronbach's α for SHAS and subscales

	Chronbach's α	**95% Confidence Interval**	
		Lower bound	Upper bound
Total scale (Q1-Q30)	0.87	0.85	0.89
Competence Appraisal	0.82	0.79	0.84
Care Futility	0.79	0.76	0.82
Client Intent Manipulation	0.76	0.72	0.80
Acceptance and Understanding	0.36	0.24	0.47
Rights and Responsibilities	0.61	0.52	0.68
Needs Function	0.55	0.44	0.63

5.4.2 Confirmatory factor analysis

A confirmatory factor analysis (CFA) was conducted using AMOS version 21, to test the scale structure proposed by Patterson et al. (2007a). During CFA the proposed structure is used to estimate a covariance matrix, which is then compared with the covariance matrix observed in the data. The validity of the proposed factor structure is demonstrated by acceptable levels of model fit, and evidence of convergent and discriminant validity (Hair et al., 2006).

5.4.2.1 Goodness of fit indices

CFA goodness of fit indices are a measure of the differences between the observed and the theoretical covariance matrices. There are a number of goodness of fit indices available to researchers. Most commonly cited are chi square (CMIN), Root Mean Square Error of Approximation (RMSEA), and Comparative Fit Index (CFI), all of which were used in this study. For continuous data, good fit is indicated by a ratio of CMIN to df of less than 2, a RMSEA of less than 0.6 (although up to 0.8 is permissible), and a CFI of above 0.95 (Schreiber, Nora, Stage, Barlow, & King, 2006). Goodness of fit indices are displayed in Table 26. The RMSEA was at the upper limit of acceptable values for adequate model fit, and the CFI and a ratio of CMIN to df indicated a poor model fit.

Table 26. Goodness of fit indices for the Self Harm Antipathy Scale

	χ^2	df	*p*	CMIN/DF	RMSEA [90%CI]	CFI
SHAS	763.36	215	<0.001	3.55	0.80	0.81

*Note. df = degrees of freedom. CMIN/DF = relative chi-square. RMSEA = root mean square error of approximation. CFI = comparative fit index. *** p < .001.*

5.4.2.2 Convergent and discriminant validity

Convergent validity indicates that items within a factor are measuring the same construct, whist discriminant validity shows that a factor is unique from other constructs measured by the scale. In this study, the following criteria were used to assess convergent and discriminant validity:

1. An average variance extracted (AVE) of more than 0.5; An AVE less than 0.5 means that the proposed factor structure accounts for less than half the average variance of the items in the factor, and so indicates poor convergent validity.

2. A construct reliability (CR) value of more than 0.7; CR is a reliability coefficient similar to Chronbach's α, where a value of above 0.7 indicates good construct reliability, and so internal consistency

3. A Maximum and Average Squared Shared Variance (MSV & ASV) less than the AVE; if a factor does not account for more of the variance within its items than it shares with another factor, it has poor discriminant validity.

These statistics are outlined in Table 27. Those that do not meet the above criteria (and so indicate poor convergent and discriminant validity) are the following (highlighted in bold); the CR for 'Rights and responsibilities', 'Acceptance and understanding' and 'Needs function' were less than 0.7. The AVE for 'Competence appraisal', Acceptance and understanding' and 'Needs function' were all under 0.5 and the MSV for 'Care futility', 'Client intent manipulation', 'Acceptance and understanding' and 'Needs function' were all higher than the AVE.

Table 27. Convergent and discriminant validity statistics of the Self Harm Antipathy Scale

Model 1	CR	AVE	MSV	ASV
Rights and responsibilities	**0.64**	0.48	0.25	0.10
Competence appraisal	0.83	**0.41**	0.36	0.13
Care futility	0.81	0.46	**1.29**	0.44
Client intent manipulation	0.77	0.47	**0.83**	0.33
Acceptance and understanding	**0.28**	**0.12**	**1.29**	0.71
Needs function	**0.59**	**0.42**	**0.80**	0.25

NOTE: CR = Construct Reliability. AVE= Average Variance Extracted. MSV= Maximum Squared Shared Variance. ASV = Average Squared Variance.

Because the CFA indicated a poor model fit, and the proposed factor structure exhibited poor construct and discriminant validity, an exploratory factor analysis was conducted to determine if a more reliable model of the data could be achieved.

5.4.3 Exploratory factor analysis

Bartlett's test of sphericity and the Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy were conducted to ensure there were sufficient correlations in the data to justify use of factor analysis. The KMO value of 0.87 exceeded the recommended minimum of 0.7 and Bartlett's test of sphericity was significant, meaning the data were suitable for factor analysis (Hair et al., 2006). Factors were extracted with maximum likelihood extraction estimates, and oblique promax rotation of factor loadings was used, since the factors were found to be correlated (Fabrigar, Wegener, MacCallum, & Strahan, 1999). Selection of the number of factors to be extracted was based on eigenvalues greater or equal to one. Following the initial extraction of factors, items with low loading (<0.3, n= 3), and low communalities (<0.3, n= 3) were removed from the model, to ensure statistical and practical significance (Hair et al., 2006). There was one

cross-loading, but this item had low loading on both factors, so was removed from the model. A five factor structure emerged, which explained 45.2% of the variance (Table 29). This structure was very similar to the model reported by Patterson et al. (2007a), minus the 'Needs Function' factor (Appendix C). The factors identified as Competence Appraisal, Care Futility and Rights and Responsibilities differed from the original structure by just one question, and the Client Intent Manipulation subscale remained the same in both models. Because the new factor structure was very similar to the structure reported by Patterson et al. (2007a), and because their interpretation of the factor structure fit well with the new model, the labels and meaning assigned to each factor by the authors of the scale were retained.

The internal consistency of the modified factor structure was assessed using Chronbach's α (Table 28). Values for the first four factors were above 0.7 indicating good internal consistency and factor 5, 'Rights and Responsibilities' had an α of above 0.6, which is permissible in exploratory research (Robinson et al., 1991). The mean scores for each factor are outlined in Table 30. This modified structure was used for all further analyses.

Table 28. Chronbach's α for the modified SHAS factor structure

	Chronbachs α	**95% Confidence Interval**	
		Lower bound	Upper bound
Competence Appraisal	0.83	0.80	0.86
Care Futility	0.82	0.79	0.85
Client Intent Manipulation	0.76	0.72	0.80
Acceptance and Understanding	0.71	0.67	0.76
Rights and Responsibilities	0.66	0.60	0.72

Table 29. Promax rotated factor loadings for a subset if variables on the Self Harm Antipathy Scale

	Rotated Factor Loadings				
	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5
23. I demonstrate warmth and understanding to self harming clients in my care	0.84				
30. I am highly supportive to clients who self harm	0.70				
24. I help self harming clients feel positive about themselves	0.65				
28. I can really help self harming clients	0.62				
27. I find it rewarding to care for self harming clients	0.61				
20. I listen fully to self harming clients' problems and experiences	0.59				
21. I feel concern for the self harming client	0.55				
26. I acknowledge self harming clients' qualities	0.42				
7. A self harming client is a complete waste of time		0.79			
10. There is no way of reducing self harm behaviours		0.78			
11. People who self harm lack solid religious convictions		0.66			
4. Self harming clients do not respond to care		0.54			
16. Self harming clients have only themselves to blame for their situation		0.45			
5. When individuals self harm, it is often to manipulate carers			0.75		
15. A self harming client is a person who is only trying to get attention			0.63		
6. People who self harm are typically trying to get even with someone			0.57		
1. People who self harm are usually trying to get sympathy from others			0.56		
14. Acts of self harm are a form of communication to their situation				0.76	
17. For some individuals self harm can be a way of relieving tension				0.64	
18. Self harming clients have a great need for acceptance and understanding				0.57	
13. Self harming individuals can learn new ways of coping				0.50	
2. People should be allowed to self harm in a safe environment					0.73
3. A rational person can self harm					0.58
8. An individual has the right to self harm					0.56

5.5 What are the attitudes of nursing staff towards people who self harm?

The attitudes of nursing staff towards people who self harm were assessed using descriptive data from the SHAS. Average total SHAS scores, and modified sub scores are displayed in Table 30. Sub scores represent an average of scores across all modified sub score items, whilst the total score is a sum of all items. Total scores are compared to those found in other samples in Table 31.

Table 30. Mean total Self Harm Antipathy score and modified sub scores

	n	*mean*	*SD*	*min*	*max*
Total score	387	80.74	20.78	36	139
Competence appraisal	387	2.20	0.81	1.00	6.63
Care futility	387	2.29	1.15	1.00	7.00
Client intent manipulation	387	3.13	1.28	1.00	7.00
Acceptance and understanding	387	2.33	1.00	1.00	7.00
Rights and responsibilities	387	4.01	1.52	1.00	7.00

NOTE: Total possible SHAS scores range from 30 – 210, whilst possible mean subscores range from 1-7.A higher score on the SHAS indicates a more negative attitude towards service users.

The mean total SHAS score was 80.74, which is towards the lower end of the possible range of scores (30-210), suggesting on the whole, relatively positive attitudes towards people who self harm in this sample. Scores are lower than those found in other populations, however are comparable to those reported by Patterson et al. (2007a). All mean subscores are also towards the lower end of the range of scores (1-7), apart from the 'Rights and Responsibilities' sub score, which suggests less agreement with statements asserting people's right to self harm. This is explored further in section 5.6

Table 31. Comparison of total Self Harm Antipathy scores between study populations

Study	Service	Professionals	*n*	*mean*	*SD*	*min*	*max*
Current study	Adult inpatient (acute, Triage and PICU)	Mental health nurses and Nursing Assistants	387	80.74	20.78	36	139
Dickinson T, Hurley M (2011)	CAMHS inpatient (secure)	Mental health nurses and Nursing Assistants	69	93.7	39.4	Not reported	Not reported
Dickinson T, Wright, K, Harrison, J. (2009)	CAMHS inpatient (secure) and Young Offenders Institute	Mental health nurses and Nursing Assistants	60	88.8	33.5	36	199
Patterson P, Whittington R, Bogg J. (2007)	Mental health, A&E, general health, forensic and learning disabilities	Mental health nurses, general nurses and social workers	153	82.7	17.8	44	126

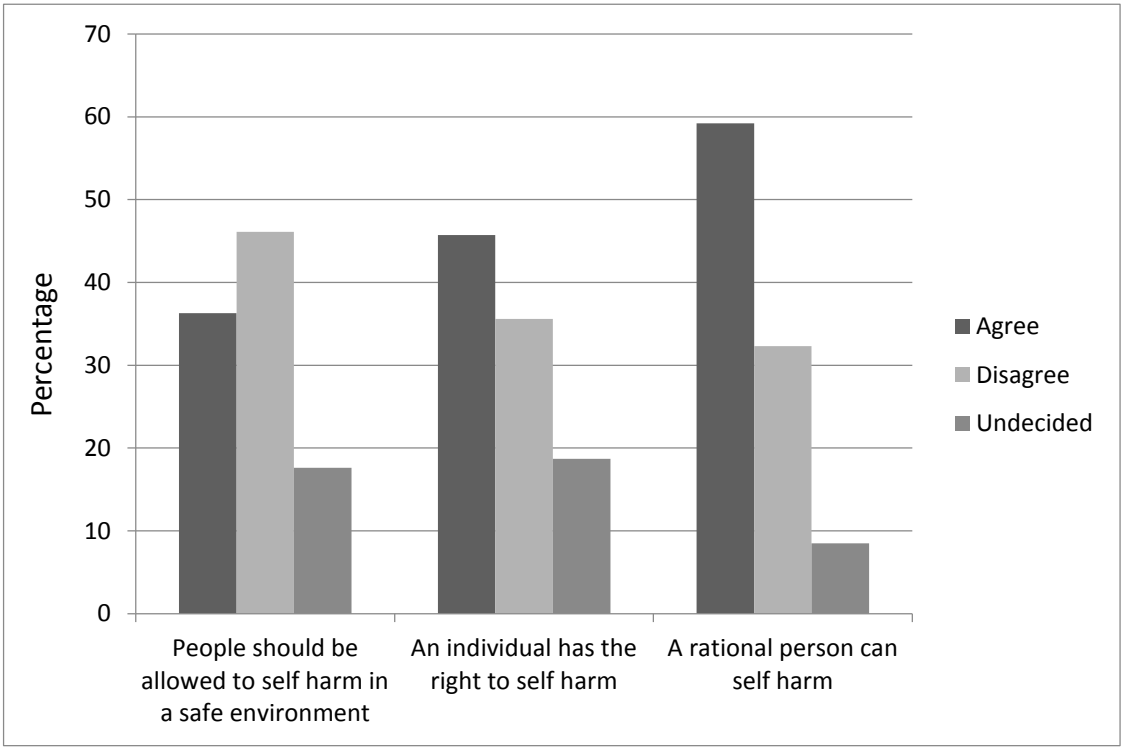
5.6 What are staff views of harm minimisation practices?

As reviewed in section 1.10, harm minimisation is a relatively new practice, where a person is permitted to self harm in a safe way during an admission. The factor 'Rights and responsibilities', is thought to reflect key beliefs related to the practice of 'harm minimisation'; namely beliefs about whether self harm should be stopped, and whether individuals should be give the freedom to choose whether or not they self harm (Patterson et al., 2007a). To recap, this factor is comprised of three items:

1. People should be allowed to self harm in a safe environment
2. A rational person can self harm
3. An individual has the right to self harm

Responses to each question were collapsed from a 7 point Likert scale (strongly agree to strongly disagree), into three possible views; agree (strongly agree/agree/somewhat agree), disagree (strongly disagree/disagree/somewhat disagree) and undecided. These data are displayed in Figure 2. Most staff did not believe that people should be allowed to self harm in a safe environment (46.1% n=175, vs 36.3% n=138 and 17.6% n=67). Most however, did believe that a person had a right to self harm (45.7% n=173 vs 35.6% n=135 and 18.7% n=71) and the majority felt that a rational person could self harm (59.2% n=224 vs 32.3% n=122 and 8.5% n=32)

Figure 2. Staff responses to items comprising the 'Rights and responsibilities' subscale



5.7 How do staff's perceptions of service users who self harm relate to their view of service users in general?

As outlined in section 3.4.6.3.4, staff views of inpatient service users in general were assessed using the Attitudes to Patients Questionnaire (APQ), a modified version of the Attitudes to Personality Disorder Questionnaire (Bowers & Allan, 2006). The relationship between staff views of all service users, and their view of those who self harm, was assessed using APQ and SHAS scores.

Chronbach's alpha for the Attitude to Patients Questionnaire was 0.89, indicating good internal consistency in this sample. A Pearson product-moment correlation coefficient was computed to determine the relationship between the SHAS and the modified APQ, and indicated a small, but statistically significant correlation between the two scales (r (354) = -0.15, $p<0.01$). Differences in APQ and SHAS scores are explored further in section 3.4.6.6.4.

5.8 Are attitudes towards self harm a property of teams, or individuals?

Differences in total SHAS by hospital, ward, ward gender and type of ward were examined using one way ANOVA, which revealed a significant main effect for ward, F(30,

353) = 1.82, *p*=.007, and hospital *F*(14, 369)=2.54, *p*=.002, but not by type of ward *F*(2, 381)= 22, *p*=.805 or gender *F*(2, 381)=1.23, *p*=.294. Tukey-Kramer post hoc comparisons indicated significant differences between just one pair of wards, and three pairs of hospitals at 0.05 level of significance. Estimates of between ward and within ward variance were used to calculate the proportion of variance attributable to the group level, and revealed that this accounted for just 14.5% of the variance.

5.9 How are attitudes towards people who self harm related to staff characteristics and wellbeing?

An analysis of possible explanatory variables for SHAS total score was conducted to identify variables for inclusion in a regression model. Possible explanatory variables are outlined in Table 12, and included demographic variables, and staff wellbeing, as measured by the Short Form (36) Health Survey (SF-36). SHAS sub scores were examined to identify any unique variables that were associated with the subscale, and not the total score, however none were found (Table 32). Independent samples t-test and ANOVA were used to examine the relationships between SHAS scores and categorical variables, whilst Pearson's *r* and Spearman's rho were used to assess the relationships between continuous and ordinal variables respectively (Tables 30 and 32)

Table 32. Correlation between total SHAS score and SF-36 item and summary scores

	Physical Functioning	**Role Physical**	**Bodily Pain**	**General Health**	**Vitality**
SHAS total score	-0.25***	-0.25***	-0.17**	0.01	0.03
	Social Functioning	**Role Emotional**	**Mental Health**	**Physical Component**	**Mental Component**
SHAS total score	-0.16*	-0.16*	-0.03	-0.24**	-0.01

*<0.001; **<0.001; ***=<0.0001

Variables found to be significant at the 0.01 level were entered into a multivariate linear regression model to estimate adjusted effects[1]. The regression controlled for clustering at the ward level using the Huber-White procedure (Huber, 1967). Backward stepwise elimination was used to drop non-significant variables from the model at the 0.05

[1] *SHAS scores were significantly correlated with a number of SF-36 items relating to physical and mental health, and also the physical, but not mental, component summary score. The physical component summary score and the social functioning and role emotional items were included in the regression analysis.*

significance level. The emerging model explained 22% of the variance (R^2=.22, F(5, 30)=24.81, p<.0001). Ethnicity, occupation and SF-36 scores for physical health and social functioning demonstrated significant and independent effects on total SHAS score (Table 33). Being a healthcare assistant, or from a non-white ethnic group were associated with higher antipathy scores, as was lower SF-36 scores for physical health and social functioning (indicating poorer physical and social functioning). Post hoc analyses revealed no interaction effects. Mullticollinearty was assessed using the Variance Inflation Factor (VIF). The VIF measures the extent to which a regression coefficient is increased due to collinearity. Acceptable levels of VIF are thought to range from <4 (Pan & Jackson, 2008) to <10 (Hair et al., 2006). In this case VIF was less than 1.5, indicating a low level of multicollinerity for all explanatory variables.

Table 33. Adjusted associations between staff characteristics and attitude to self harm

	β (95% Confidence Interval)	***p***
SF36 score		
Physical Component	-0.50 (-0.76 to -0.24)	<0.001
Role Emotional	-0.12 (-0.24 to 0.00)	0.05
Ethnicity		
White	Reference	
African	11.00 (5.55 to 16.45)	<0.001
Other	14.66 (10.67 to 18.64)	<0.001
Occupation (Nurse/HCA)	11.66 (7.35 to 15.97)	<0.001

To determine whether these were unique effects for attitude towards self harm, or a result of a more general attitude towards service users, the relationship between explanatory variables and total APQ score were investigated using ANOVA, independent samples t-test and Pearson's *r* (Table 35). There were no significant differences in APQ score by occupation, there was however a significant effect for ethnicity, but in the opposite direction to that seen with the SHAS. The SF-36 social functioning score and APQ total score were significantly, and highly correlated ($r(334) = 0.39$, p<0.0001), whilst there was no effect for SF-36 physical health sub score ($r(334) = 0.09$, p=0.12).

Table 34. Bivariate analysis of SHAS scores and sub scores and possible explanatory variables for regression analysis

	P (total score)	*P/f/t (total score)*	*n*	Total Score	*SD*	Comp	*SD*	Futility	*SD*	Manip	*SD*	Accept	*SD*	Rights	*SD*
Age	<0.001	0.18													
20-29			46	**73.9**[a,b,c]	22.55	2.15	0.78	**2.07** [a,b,c]	0.96	2.96	1.23	2.19	0.66	3.40	1.40
30-39			48	**77.80**[a]	19.75	2.19	0.84	**2.01**[a]	1.06	3.00	1.19	2.24	1.01	4.10	1.50
40-49			123	**80.20**[b]	20.82	2.16	0.77	**2.26**[b]	1.25	3.05	1.36	2.30	1.00	4.00	1.54
50 or over			118	**84.70**[c]	19.14	2.26	0.78	**2.51**[c]	1.11	3.37	1.24	2.46	1.04	4.09	1.50
Gender	0.01	2.21													
Male			152	**83.61**[*]	18.75	2.14	0.73	2.34	0.90	3.25	0.07	**2.57**[*]	1.08	**4.23**[*]	1.44
Female			222	78.83	21.63	2.25	0.86	2.26	0.79	3.07	0.01	2.18	0.92	3.85	1.56
Ethnicity	<0.0001	15.54													
White			106	**71.12**[a,b]	20.79	2.23	0.77	**1.87**[a]	0.95	2.83	1.21	2.12	0.85	**3.20**[a,b]	1.24
African			165	**84.08**[a]	19.94	2.12	0.84	**2.45**[a]	1.26	3.13	1.35	2.39	1.07	**4.50**[a]	1.52
Other			87	**83.68**[b]	18.52	2.33	0.82	2.35	1.03	3.34	1.16	2.44	0.97	**4.02**[b]	1.44
Time in post															
1 year or less			59	74.89	21.50	2.19	0.82	2.04	1.17	2.86	1.05	2.02	0.84	3.78	1.38
1 to 3 years			94	79.37	22.64	2.13	0.73	2.23	1.14	3.20	1.38	2.40	1.01	3.80	1.52
3 to 5 years			48	79.91	20.56	2.60	0.91	2.27	1.24	3.17	1.26	2.22	1.09	4.01	1.73
More than 5 years			168	83.36	18.90	2.27	0.82	2.39	1.12	3.18	1.30	2.45	1.03	4.16	1.48
Time in mental health	0.01	-2.22													
Up to 5 years			89	**76.52**	21.19	**1.98**[*]	0.07	2.14	0.11	3.00	0.12	2.24	0.11	3.99	0.17
More than 5 years			284	82.05	20.26	2.28	0.04	2.34	0.07	3.18	0.78	2.78	0.06	4.00	0.10
Occupation	<0.0001	-5.66													
Nurse			239	**76.79**	1.30	2.17	0.05	**2.16**[*]	0.07	**2.98**[*]	0.08	**2.18**[*]	0.03	**3.73**[*]	0.01
Heathcare Assistant			119	89.20	1.67	2.26	0.07	2.56	0.10	3.44	0.11	2.72	0.10	4.57	0.14
Dependent Children	<0.01	2.53													
Yes			215	**82.8**	20.18	2.19	0.81	**2.40**[*]	1.2	3.13	1.27	2.36	1.20	**4.22**[*]	1.5
No			150	77.3	21.2	2.21	0.83	2.10	1.06	3.14	1.29	2.29	1.03	4.00	1.5

	P (total score)	P*/f/t (total score)*	*n*	Total Score	*SD*	Comp	*SD*	Futility	*SD*	Manip	*SD*	Accept	*SD*	Rights	*SD*
Marital Status															
Single			82	79.31	21.62	2.23	0.74	2.21	1.04	3.21	1.21	2.37	0.83	3.72	1.47
Divorced or separated			39	83.72	23.81	2.50	1.19	2.31	1.06	3.17	1.35	2.60	1.45	3.77	1.62
Widowed			7	92.25	19.83	2.56	1.31	2.27	0.52	3.86	1.59	2.75	1.49	4.56	1.73
Married or cohabiting			238	80.35	19.66	2.14	0.73	2.29	1.18	3.08	1.27	2.29	0.96	4.14	1.49
Mild physical violence exposure															
Never			39	80.96	20.34	2.07	0.76	2.39	1.18	3.14	1.24	2.33	1.11	4.51	1.79
Occasionally			143	76.99	19.98	2.13	0.77	2.12	1.07	2.92	1.29	2.25	0.93	3.87	1.46
Sometimes			110	85.53	20.37	2.24	0.76	2.53	1.25	3.45	1.27	2.54	1.13	4.02	1.46
Often			42	82.27	21.70	2.41	1.14	2.23	1.02	3.24	1.36	2.28	0.92	3.95	1.44
Frequently			37	76.90	20.52	2.22	0.70	2.02	0.99	2.91	1.01	2.14	0.88	3.94	1.66
Severe physical violence exposure															
Never			258	79.42	20.83	2.16	0.75	2.24	1.17	3.15	1.30	2.29	0.98	3.98	1.50
Occasionally			63	81.93	21.58	2.36	1.07	2.33	1.19	2.97	1.32	2.44	1.22	3.82	1.55
Sometimes			38	86.71	19.40	2.23	0.77	2.58	1.03	3.34	1.18	2.51	0.91	4.39	1.58
Often			6	73.77	11.77	2.20	0.83	1.83	0.57	2.79	0.80	2.08	0.47	3.89	1.87
Frequently			5	88.80	13.08	2.23	0.58	2.44	0.84	3.30	1.24	2.35	0.95	4.60	1.62

NOTE: Means with the same superscript letter differ significantly at p<0.05 (Tukey Kramer post Hoc analysis)

*****Bivariate analyses of subscales significant at the p<0.01 level

Table 35. Relationship between APQ score and Ethnicity and Occupation

	APQ total score		
	n	Mean	*SD*
Ethnicity			
White	103	23.49[a, b, c]	2.81
Irish	8	22.73	3.72
Caribbean	27	25.15[a]	3.03
African	149	25.16[b]	2.46
South Asian	13	24.67	2.08
Other	44	25.11[c]	2.40
Occupation			
Nurse	222	24.50	2.65
Healthcare Assistant	108	24.75	2.89

a. b. c; Tukey-Kramer; p<0.05
NOTE: A higher score on the SHAS indicates a more negative attitude, whilst a higher score on the APQ indicates a more positive attitude.

5.10 Summary of findings

Confirmatory factor analysis of the SHAS had a poor model fit, however this appeared to be mainly due to the 'Needs function' factor, as the exploratory factor analysis revealed a very similar structure to that proposed by Patterson et al. (2007a). The mean total SHAS score was towards the lower end of the possible range of scores, and there was large variation in scores within teams. Responses to questions reflective of the principles of harm minimisation (Rights and responsibilities factor) indicated mixed views of this practice amongst inpatient nursing teams. Being a healthcare assistant, or from a non-white ethnic group were independently and significantly associated with higher antipathy scores, as was lower SF-36 scores for physical health and social functioning (indicating poorer physical and social functioning). There was a small, but significant, correlation between SHAS score and scores from the Attitudes to Patients Questionnaire (APQ). Effects for ethnicity and occupation were not replicated in APQ scores.

6. Results: Study 2, Phase II

This chapter presents the results of Phase II of Study 2. As outlined in section 3.4, Study 2 was an investigation of attitudes towards people who self harm amongst inpatient nursing staff, and followed a sequential explanatory design which comprised of two phases:

Phase I: a survey of staff attitudes towards people who self harm, using the Self Harm Antipathy Scale (Patterson et al., 2007a)

Phase II: semi structured interviews exploring staff understandings of self harm, and views of harm minimisation practices.

This chapter first outlines the selection of participants for Phase II, followed by a thematic analysis of interview data collected during this phase, presented in answer to the research questions, as follows.

1. What is inpatient nursing staff's understanding of self harm?
2. How do staff come to reach their understanding of self harm?
3. Do nursing staff distinguish between acts of self harm and attempted suicide, and if so, how?
4. What are nursing staff's views of harm minimisation practices?

This phase adopted an extreme group sampling strategy, which was used to maximise the chances of rich and contrasting accounts of self harm. The study did not set out explicitly to compare accounts from high and low antipathy staff; this was a strategy for sampling, and not analysis. Nevertheless, differences between these two groups of staff are important, as they may reveal why people develop a positive, or negative, attitude towards people who self harm, and will also provide information about the validity of the Self Harm Antipathy Scale. Although there were no systematic differences in the themes arising from interviews with high and low antipathy staff, there were differences in the prevalence of certain themes. This is discussed at the end of the chapter. To illustrate this point, both high and low antipathy participants are quoted where possible. Antipathy score is indicated by a prefix of Hi, for a high antipathy participant, and Lo, for low.

6.1 Recruitment

Ten participants were randomly selected from staff within both the top, and bottom, 10th percentile of antipathy scores, respectively (Table 36). Staff who had participated in the experimental arm of the Safewards trial were not eligible to participate in the interviews (see section 3.4.7.2 for discussion of exclusion criteria), which left a total of 23 participants with low SHAS scores and 28 with high scores for this phase of the study. Eligible staff were listed in a random order, and the first ten from each group were invited to participate. Three participants from the high antipathy group declined; one due to personal reasons, one because they no longer worked on the ward, and one did not give a reason. Where staff declined to participate, the next person on the list was approached.

Table 36. Self Harm Antipathy Scores, showing scores for total sample, top and bottom 10th percentiles and interview sample.

	n	*mean*	*SD*	*min*	*max*
Total sample	387	80.74	20.78	36.00	139.00
Total sample: Bottom 10th percentile	42	47.92	5.28	36.00	55.00
Total sample : Top 10th percentile	37	119.43	7.31	110.00	139.00
Interview sample: Bottom 10th percentile	10	46.90	5.99	36.00	52.00
Interview sample: Top 10th percentile	8	118.50	10.92	111.00	139.00

Recruitment and data collection for this phase of the study took place over period of 9 months. All interviews with staff from the low antipathy group were complete within 10 weeks. Recruiting high antipathy staff however, was far more difficult. Despite daily phone calls to the wards, and weekly emails, it took a long time to get a response from staff. On eleven occasions where staff said they were happy to participate, interviews were cancelled last minute, or participants would arrange an interview for days when they were not working, or would not be on the ward at the agreed time. Consequently, it took six months to complete eight interviews with high antipathy participants and a further three months were spent attempting to conduct the final two interviews. To maximise the chances of data collection during this time, all eligible participants were invited to participate via email, and then follow up calls were made to the wards until four members of staff agreed to be interviewed. This took one month, and the following two months were spent attempting to meet with staff. No interviews were conducted during this time because of the problems cited above. This meant that because of the time limitations of

the project, eight, not ten, interviews were conducted with staff from the high antipathy group.

6.2 Sample characteristics

There was a mean difference of 71.6 in SHAS scores between high and low antipathy staff (Table 36), all other sample characteristics are displayed in Table 37.

Table 37. Sample characteristics

	Low antipathy	High antipathy	Total sample
Age			
20-29	2	3	4
30-39	3	3	6
40-49	5	1	6
Gender			
Male	4	1	5
Female	6	7	13
Ethnicity			
White	5	1	6
Caribbean	0	1	1
African	5	4	9
Other	0	2	2
Occupation			
Nurse	9	4	13
HCA	0	4	4
Other	1	0	1
Time in post			
1 year or less	1	2	3
1-3 years	4	3	7
More than 5 years	5	2	7
Time in psychiatry			
1 year or less	0	1	1
1-3 years	0	1	1
3-5 years	1	2	3
More than 5 years	8	3	11

6.3 What is inpatient nursing staff's understanding of self harm?

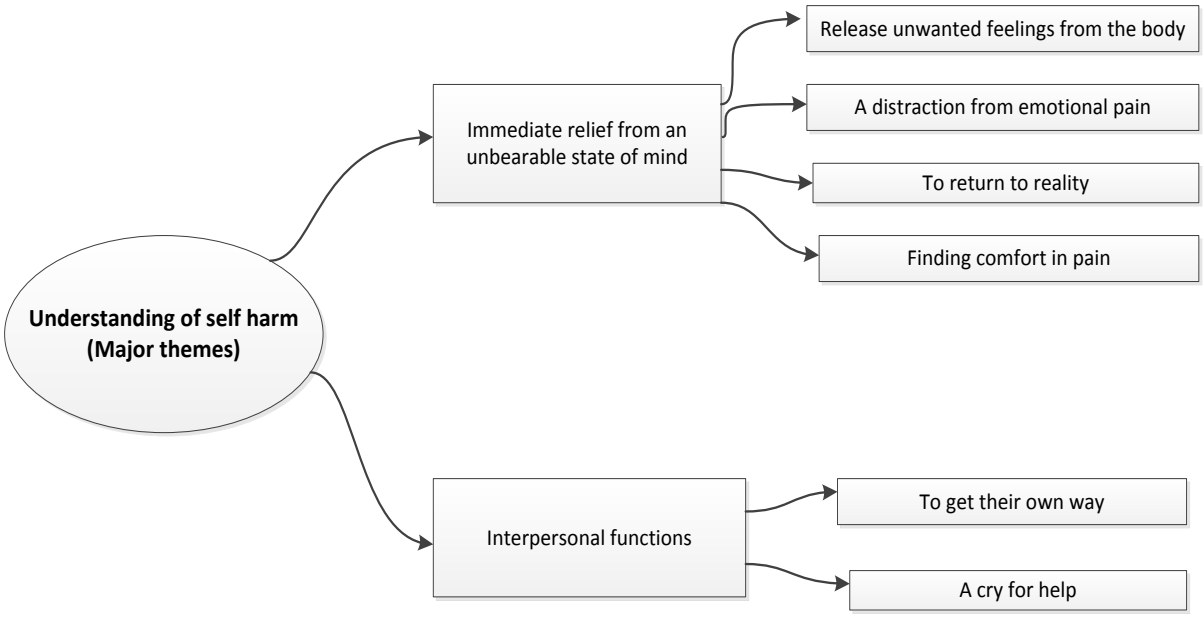
The reasons for self harm are complex and varied, and this was reflected in participants' accounts of the behaviour. A number of understandings featured in almost all interviews, and were discussed in detail, others however were only mentioned in a few. In order to give a complete and accurate representation of staff's understanding of self harm, the data were grouped into major themes (mentioned by many, discussed at length) and

minor themes (mentioned by few, briefly discussed). In this section major themes are presented first, followed by a summary of minor themes.

6.3.1 Major themes

The most common understandings of self harm were that it provided people with immediate relief from an unbearable state of mind, or that it was used to influence the behaviour of others. Within these main themes, there were several subthemes which represented differences in the nature of these understandings (Figure 3)

Figure 3. Major themes representing nursing staff's understanding of self harm



6.3.1.1 Immediate relief from an unbearable state of mind

Self harm as a way of providing immediate relief from an unbearable state of mind was mentioned in all but two interviews, and was the most common understanding of self harm. Staff offered a range of descriptions of service user's state of mind, including, stressed, distressed, painful, frustrated, sad, anxious, worthless and hopeless. A commonality across all accounts, however, was that this suffering was extreme, unbearable and unrelenting. There were also important differences in the ways in which participants described *how* self harm offered people relief (Figure 3). These are summarised below.

6.3.1.1.1 To release unwanted feelings from the body

A common explanation, which featured in just under half of interviews, was that self harm was a way for people to release unwanted feelings from their body:

> *Lo1: "Well, many people - judging by what they say, isn't it? - say that drawing blood or something like that - pain or burning or something - is a way of their mental torment and pain - to have this released. It seems to have that effect, really, you know because you can see people cut. They're doing that like a pressure cooker. You can see they're in not a nice place. Then, after that, it is like they are more relaxed."*

> *Lo2: "How else can I vent my frustration when it seems to be constant? I get these feelings of worthlessness constantly…I think part of it was it meant that she could release some of that inner emotion, that inner tension that seemed to be constantly going round"*

> *Hi2: "She was very bogged down with all this emotion, complexity of her feelings, of not being able to trust anyone when close family did that [abuse] to her. It was a quick release for her…All she was telling us was that it was an intense feeling of sadness; of feeling that she had to let out something, either through bloodletting or superficial cuts. It was a tension."*

Here participants use the words *"intense"* and *"torment",* to indicate that the levels of distress experienced by these service users are extreme. Their distress is described as an unbearable "*inner tension*", which is "*constantly going round*", or causing people to be "*very bogged down*". And so, the experience is understood to be unrelenting, and all consuming. Lo1 uses the simile of a *"pressure cooker*", to describe how this tension builds up inside, whilst Hi2 explains that people reach a point where it this tension *has* to be let out, and so, like removing a valve on a pressure cooker, self harm provides a "*quick release*". The release of blood from the body appeared to play an important role in this effect as the drawing of blood was seen to symbolise the flow of emotions leaving the body:

> *Lo2: "Sometimes they need visibly to see blood. Sometimes they need that release, that tension just releasing out of their body"*

> *Hi3: "Well she says she feels better, it's like the pain comes out so for her it's a good thing to do it."*

Hi4: "Quite a common thing is the fact that it's a blood-let…all the pain and everything else that they have experienced has oozed out, and has gone"

6.3.1.1.2 A distraction from emotional pain

Three members of staff felt that self harm served as a distraction from people's thoughts or feelings. Here Lo2 describes a case of self ligature:

Lo2: I think it was distraction, partly. Partly it was the physical sensation of what happens if you put something round your neck. Clearly you've got to concentrate on what's happening in that moment in time. I think that was a distraction.

He believes that by placing a ligature around their neck, this person became distracted from their state of mind because it meant their focus was shifted from the "*inner emotion*", to the "*physical sensation*". In contrast to this account, two participants describing acts of self harm by cutting, felt it not only caused a shift in attention, but also changed the nature of the pain they were experiencing:

Hi1: *"I think it sort of, diverts their attention, their pain, sort of, gets diverted. Um … yeah."*

Lo7: "I think they would describe it as a distraction from their thoughts…It was focusing on something else, where the pain was channelled in a different way. Rather than it being emotional pain anymore, it was physical pain that they were feeling."

Here, unlike previous accounts, the pain is not released from the body, but is transformed from the emotional into the physical.

6.3.1.1.3 To return to reality

Two participants believed that self harm was a way for people to escape memories of abuse, or voices related to past experiences of abuse:

Lo6: "*Erm...yeah, that's why, he self harms because he can't deal, he's had like counselling and stuff, but he can't deal with it, what happened to him as a child… [the voices] are quite derogatory and say negative things about him and actually accuse him of doing what the person did to him when he was a child …harming himself it kind of bring him back to reality and he finds that that, kind of, seeing the pain that he inflicts on himself kind of brings him back to reality"*

By using the term "*come back to reality*", Lo6 explains that this person has entered a different state of consciousness, and that the pain caused by self harm enables him to leave this distressing state of mind.

6.3.1.1.4 Finding comfort in pain

One nurse gave an account of someone who self harmed because pain was a comfort to him:

> *Lo8: "He was having thoughts in his head that he couldn't shake off and the only way, the only thing that worked for him at that time, was actually self harming. After self harming the thoughts would go away and he would feel human again and carry on…He had a lot of life experiences where things were quite painful and yet no one to turn to. So pain for him was a healthy thing. He had learnt to like it. .. So it's part of him and it's recovering from the pain… and that was the feeling he held on to"*

Lo8 explains that because this person had experienced a lot of pain during his childhood, feeling pain was something that was "*healthy"* for him, and because the process of recovering from pain meant that his suffering was over, it was comforting. For him, pain was normal and helped him to feel "*human again*".

6.3.1.2 To influence the behaviour of staff

All but three participants felt that self harm was used as a way for people to influence the behaviour of staff. This was understood to be either a 'cry for help' or a method for people to 'get their own way' (Figure 3). These themes were defined as follows:

1. A cy of help: a way for people to access support from staff during times of distress
2. To get their own way: a way for people who are not in distress to gain access to something they want

6.3.1.2.1 A cry for help

In these accounts participants described self harm as a way for people to show they are in distress and to access support from staff:

> *Lo3: "We do have some patients that will - there's no doubt about it; they'll regularly admit that to me - use it as a form of saying, "I need someone to talk to me. I need some help"*

Hi4: "I think it's to alert us how they're feeling as well. Sometimes talking therapies aren't enough for somebody. Medication sometimes isn't enough for somebody."

Lo3 identifies self harm '*a form of saying*', whist Hi4 describes how it's used '*to alert'* staff to how people are feeling and so here, self harm is seen as a form of communication. Hi4 explains how the interventions offered to people who self harm are not always '*enough*'; suggesting that there is something more they need from the service. Several staff described people who self harm as having an intense need to feel cared for:

Hi1: *"it makes them feel as though they're not alone, and then, erm, it starts to, yeah, I, they start to feel better after that"*

Lo4: "They just want to feel belong, feel loved, you see what I mean? And sometimes it can be craving for that emotional support, that's what most of them do"

At the same time, however, participants felt that people were unable to ask for the support they needed:

Hi8: *"Because sometimes it's not easy for someone to actually just come out and tell you what they're experiencing. Sometimes, some people would rather be approached and you notice that, "Oh, that looks fresh, when did that happen?" You know, "How were you feeling at the time? What was going through your mind? Were you upset, were you anxious about anything?" The person can then engage with you…It's only because it's visible, you can see the scars, that's why you can go to it."*

Lo2: "It was almost like she needed some baseline to express herself. She couldn't just do it by coming to staff and saying, "I don't feel good about myself. Can you give me a pep talk?" It was, "I feel so bad about myself I don't want to be around anyone. I'm so undeserving I've got to do something first before I deserve even a chat"

Here Hi8 and Lo2 both describe people who find it difficult to ask for support, however the role of self harm in these situations is understood in different ways. Hi8 explains how the scars of self harm cause staff to approach the service user, and ask them a series of questions, which then "*allows"* the person to talk about their feelings. Lo2 gives an account of someone who has self harmed using a ligature, and so in this case the scars are unimportant. He believes this person feels '*undeserving*' of support, and so was only

able to ask for it after he had self harmed. Self harm was not only seen as a way of accessing support in a moment of distress, but also in the longer term, by prolonging a stay in hospital:

> *Hi2: "We perceived him as wanting to depend on some kind of services to actually - just that feeling of dependency, so that he can be supported and looked after. So it was a cry for attention; for being looked after. You know".*

> *Lo6: "A lot of people, I've seen a lot of people do it because they don't want to be discharged. They're scared to go out again in the community. They haven't got anywhere to go. So they feel that if they self harm they could stay here for longer, or they get put on one to one so then they'd have nurses with them all the time, so then they could never feel by the way side."*

One participant gave an account of a service user who had been refused asylum. He was asking for help, but was not being heard:

> *Lo5: "it is the only way he can, maybe raise an alarm, make people be aware that what's he's saying is not like what other people will do, where they will say 'if I go home I'll be tortured', simply because they want to stay here indefinitely, where as in reality, they will do nothing like that to them. So that was (his) influence in attempting to harm himself"*

Here self harm is described as a way to '*to raise an alarm*', and so, like previous descriptions, is understood to be a form of communication. In this case however, self harm is seen as a way for the service user to communicate the seriousness of his situation; to illustrate his case is different from "*what other people will do"*. He hopes the extreme act of harming himself will mean that he is believed. In accounts of self harm as 'a cry for help', staff made a distinction between their views of self harm, and the belief that self harm is 'attention seeking':

> *Hi8: "It's the attention aspect. It's not so much a cry for attention as in, "Please help me", it's "Can you just distract me from feeling what I'm feeling?"*

> *Hi1: "I felt like, you know, self harm, these people want, want attention, but the wrong kind of attention, and people shouldn't encourage them in any way, make them feel like it's ok, and should, you know, just sort of dismiss when they self harm, just don't really engage with them and stuff, just isolate them*"

Here Hi8 initially uses the term 'attention', but then quickly corrects himself- he says self harm is actually not about attention, but a way of asking for help. Hi1 explains she used

to believe people were seeking the '*wrong kind of attention*', and should not be given support. It seems that by 'the wrong kind of attention' she means attention people do not need. She later goes on to explain she now realises people who self harm are in need of support. Central to the understanding of self harm as a 'cry for help' is the recognition that people are self harming because they are suffering:

> *Lo2: "I think self harm is a very misunderstood behaviour. I think it's very easy to see it as attention seeking. I think it's very easy to see that actually there is no real motive or purpose behind it, that sometimes people think they're only self harming because they're not getting attention from staff or friends or family at this moment in time. That is their only reason. I disagree with that. I think that's never the reason. I think the reason why people self harm are, like I've said, they don't feel good about themselves. They literally do not know how to express themselves in any other way."*

> Lo9: *"One thing that I found useful is how she managed it the first time, especially on the ward, if she's not supported you know she'd tend to do more and more. And it's not that she was seeking attention you know, she was just doing it because she feel that she is not actually, did I say the hopelessness that she was talking about, or no hope you know."*

6.3.1.2.2 To get their own way

Half of participants felt that, in some cases, self harm was used to ensure the individual got 'their own way'. This theme was similar to 'a cry for help', in that self harm was used as a way to influence the behaviour of others, however here, the behaviour was understood to be a way for people to get something they wanted, rather than to access emotional support, which they needed:

> *Hi1: "Just to get his own way, I think. Each time he done that after a certain situation where he can, like for example with medication, then, you, you follow up the doctor to make sure that he does get it written on his chart so you know, he gets his own way. That's what happens in a lot of situations."*

> *Lo6: "Yeah. I mean some people self harm say, if they, if we didn't take them out for a cigarette say and certain people would then do it for that. Yeah, I mean some people's reasoning for self harming, like some will just do it because they don't get the attention that they feel that they need, or people, their needs aren't immediately met."*

Lo6 goes on to describe self harm as a '*weapon*':

> *Lo6: "I mean, I think to them they use it as more of a weapon towards people, whereas other people try and hide it, conceal it and it's more of a personal thing and they use it for themselves, more than to get an effect from other people."*

This powerful description conveys the control she feels people who self harm have over others. She contrasts this with "*other*" people who "*use it for themselves*", referring to those who use self harm to relieve stress, which she views as a more legitimate reason for self harm. In the first extract, she not only talks about people having access to something they wanted, i.e. a cigarette break, but also attention. This was a common feature in accounts:

> Lo7: *"It's the patients who come in, and it's just they're not getting enough attention from their parents, or whoever. That's personally how I feel with some of the patients that come in; they're not getting their own way, so this is what they do. Then all of a sudden everybody is rushing around them".*

> Hi3:*"Some of them I would say it was as well for erm, attention. Yeah some was for attention like things like that, rushing to the hospital coming to visit them, things like that."*

> Hi7:*"She's attention seeking, it's purely attention seeking. When she does it, she comes to a member of staff "oh I've overdosed" you know and then she just enjoys the drama of people running around her...It's just attention."*

In contrast to earlier accounts of self ham as 'a cry for help', people here are not seen to be seeking support, but wanting simply "attention"- i.e. people "*rushing*" or "*running*" around them. In these cases staff felt that people did not need their help:

> *Hi7: "I tend to the more unwell patients than I tend to this particular patient I told you about because I know there's nothing wrong with her. There's absolutely nothing wrong with her. She's just seeking attention."*

> *Lo7: "Some of these girls are genuinely tormented souls; they're totally tormented, absolutely tormented. Then, you get other ones come in, they're not getting what they want from their mum and dad. So they've started self harming, and realised that by self harming, two, three or four years down the line, they're still doing it, because they know that's the way they get the attention."*

Lo6: "If somebody has reasons to do it that are more permanent and will be more prolonged in their life then its, people that do it for say the attention reasons- they probably wouldn't be doing it for such a long time."

Here Lo7 describes these service users as "*the other ones*", again, clearly distinguishing them from those who are self harming to relieve distress. She believes these people are different because they are not seen to be suffering. Lo6 refers to this group as those who do it for "*the attention reasons*", and presents them as having less chronic problems than others, whilst Hi7maintains there is "*absolutely nothing wrong*" with them. Rather than describing these cases in terms of psychiatric illness, or psychological distress, some staff used the term '*behavioural*':

Hi7: *"We're just tired, because part of this is behavioural and seeking attention"*

Hi4: "*Sometimes it can be behavioural. It has been spoken about individuals doing it on the behaviour side of things"*

In contrast to other understandings of self harm, which were related to past trauma or neglect, or depression, Hi4 attributed this behaviour to the individual themselves. She believed it was part of their character:

Hi4: Yes, it could be in reaction to something, say that their leave had been stopped. That's then an adverse effect of that. They then self harm. It doesn't help any situation. It doesn't get the leave back, does it?… What was I going to say about behaviour? It does depend on the character of the person as well."

In contradiction to these accounts however, staff did at times, appear to be aware that people who self harmed had a mental health problem, or were in need of support:

Hi7: "*Personally, I think she's just doing it to get attention, that's it. It's so unfortunate, she must have had crappy childhood, she's very unfortunate; no child should go through that."*

Hi4: "*That's what it comes down to a lot, about how they were brought up. That's massive, I think…I think they're just so desperate to get the help*"

Lo6*: "But I mean people, some people, say you've got schizophrenia and you're self harming, I mean I think it's a lot different to having a personality disorder, where you're quite aware of yourself and aware of the things you're doing and you're doing it, say to manipulate the situation".*

Unlike accounts of self harm as 'a cry for help', staff described feeling upset and frustrated when working with people who were seen to be using self harm to get their own way:

> *Hi7: "I went to my manager, and like you know what yeah I'm not happy about this, and I told my colleagues, I said from now please nobody should allocate … I don't want to be her nurse from now, because I'm very upset about this, it's very very upsetting."*

> *Lo7: "Those are the people that self harm that I get frustrated with. Like, 90% of the patients who come in and who have self harmed I've got as much time as I have for somebody who's psychotic, I've all the time in the world."*

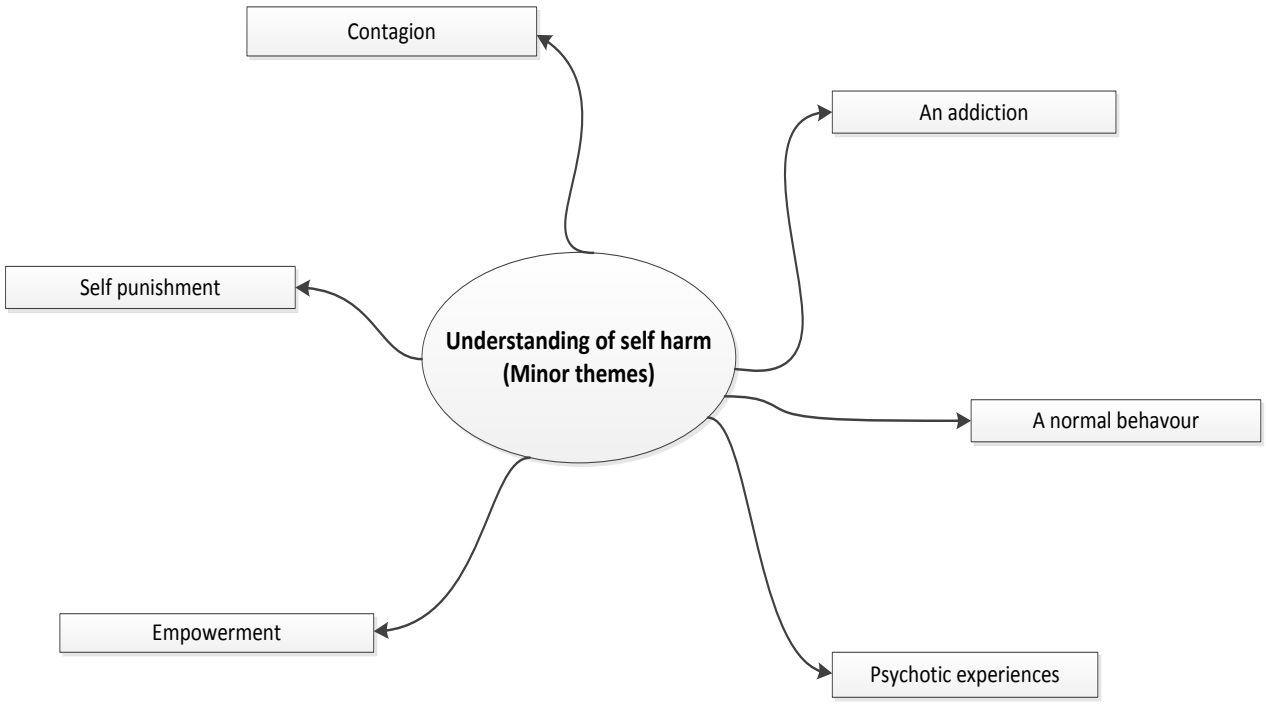
6.3.1.3 Summary of major themes

Staff commonly described two types of self harm; that which offered people relief from an unbearable state of mind, and self harm which was used to influence the behaviour of others. Participants described a variety of ways in which they felt self harm allowed service users to escape their emotional pain, revealing the complexity of this behaviour. All however, believed these people were experiencing extreme levels of emotional distress, and saw self harm as providing an immediate respite from this. The majority of participants felt that self harm could also be used to influence the behaviour of staff. This was also understood in different ways; as a form of help seeking behaviour, used when people needed to be cared for, listened to, or taken seriously, and as a way to for people to manipulate others in order to get something they wanted. Self harm used as 'a cry for help' was seen to be a legitimate behaviour, used by people who were in need of support, while people using self harm 'to get their own way' were believed to have nothing wrong with them, and their behaviour was not accepted by staff.

6.3.2 Minor themes

Minor themes reflected understandings of self harm which were shared by a minority of staff, and were not discussed in depth during the interviews. These are displayed in Figure 4 and outlined below**.**

Figure 4. Minor themes representing nursing staff's understanding of self harm



6.3.2.1 An addiction

A third of staff saw self harm as a form of addiction:

> Hi4: "*They do get quite an adrenaline – they get off on that in some way, as a release… until that feeling and that emotion comes back again, and they want to do it again because it felt so good last time. That's quite a common theme."*

> Lo3: *"Because sometimes people will begin a process of – self harm will be an expression of emotional pain, and then it becomes almost like a habit … it's almost become a bit of a habit, which is a horrible thing to say, but that's, in effect, what it is. It started somewhere way back when, and they have almost become addicted to it and haven't been able to stop"*

> Lo8: "*They don't feel the pain the same, so they have to go that bit deeper, or they'll need more stitches to show for it. So it escalates. So just like in cocaine addiction, a person tries it once they like the feel of it, then they say, oh ok, this is something I might try once a month, and then when once a month becomes once a week and once a week becomes maybe a bit every day and then from every day it becomes several times a day till, and some people describe their self harm to be something similar, where it starts off occasional and then it turns up fully blown."*

Here staff outline the powerful impact self harm can have on a person's mood. Hi4 describes the addictive properties of self harm: "*they want to do it again because it felt so good last time".* Lo3 explains that although self harm can initially be used as a cry for help in times of distress, it can quickly become a routine part of life because it is very difficult to stop. Lo8 describes how, a drug addiction, once a person has started self harming the frequency and severity of the behaviour can escalate.

6.3.2.2 A normal behaviour

Six staff saw self harm as part of a range of socially acceptable behaviours such as smoking and drinking:

> Hi8: "*Everyone self harms, because self harming is not only lacerating your skin. Self harming is knowing that you're diabetic but refusing to take your insulin, or you consume sugar. Self harming is you go on a drastic diet, "I want to lose weight, I'm not going to eat – one meal a day". Self harming is kind of giving in to things that you know aren't good for you but they bring that satisfaction in some sort of way, if you know what I mean?*"

> Hi2: "*There are different ways of self harming. It could be a person overdosing, poisoning. There are all sorts of ways of self harming. It could be driving recklessly, or binge drinking, drug-taking, unsafe sex. Those are all self harming behaviours*"

For Lo1, this also included behaviours which not only were a risk to physical health, but also emotional wellbeing:

> Lo1: "*I think hurting yourself, I think we do ourselves; I mentioned the tobacco. Sometimes, it could be not something physical but mentally you put yourself in some situations.*"

By explaining that everyone self harms Hi8 and Lo1 present it as part of a spectrum of 'normal' human behaviour. Lo3 did not share this view, however, was concerned that it may be becoming more 'normal' amongst young people:

> *Lo3: "I think what's quite worrying, I guess, about self harm is that it seems to be significantly on the increase, especially in a much younger group now. My son tells me that half the girls in his year at school self harm. He says it like its normal."*

6.3.2.3 Psychotic experiences

Five participants gave accounts of people who had self harmed because of psychotic

experiences, which were either voices telling them to self harm (command hallucinations), or a belief that they were evil inside, and so must let the 'bad blood' out of themselves:

> *Lo6: "So when he drinks, it gets worse, and the voices tell him to harm himself, so he self harms worse when he drinks"*

> *Lo3: "Sometimes the psychosis can represent satanic, evil, spiritual type phenomena. With that, they believe that their system is poisoned, and that the only way to get that satanic stuff out is to bleed themselves, because they feel then they're regenerating new blood, which is cleaner and more spiritually clean"*

6.3.2.4 Contagion

Four members of staff described cases where they believed people had started self harming because they were copying another service user on the ward:

> *Hi3: "Some, sometimes I think it's because some of the people have been on the ward and they've looked at the other patients and then they started doing it as well when they probably never have done it before."*

> *Hi6: "It was about 4 patients who were doing it and it's like they were copying each other. If someone self harms, one of them wants to do it more. I don't know why they were doing it"*

6.3.2.5 Self punishment

Three participants understood self harm to be a response to extreme feelings of low self-worth, or a re-enactment of past abuse.

> Lo2: "*Okay. Well the one that springs to mind, it was because she said she felt worthless, she felt she didn't deserve good things in life. She felt she had to be punished and if no one else was going to punish her she had to. "*

6.3.2.6 Empowerment

Three members of staff felt that self harm was a way for people to gain more control over their lives. This was particularly meaningful during an admission where they were legally detained and so had very little control:

> *Lo5: "Being able to control...because he hasn't got any power for him to leave the hospital. He didn't want to stay here. He felt that by self harming he would be able to control his own emotions, you know. And as he's doing it he feels*

empowered. It's the only way. It's the only thing he has control over, where he can say 'I'm going to do this' and he ends up doing it.

6.3.2.7 Summary of minor themes

Here again the complexity of self harm is revealed in participant's wide ranging, and diverse understandings of the behaviour; self harm is described as an addiction, a result of psychosis, and a facet of normal human behaviour. Some staff believed people started self harming because they had seen others doing it. Self harm was also understood to be a form of self-punishment, and a way for people to feel in control.

6.4 How do nursing staff come to reach their understanding of self harm?

All but one participant were able to give an account of how they came to reach their understanding of self harm. The ways in which staff constructed their understanding were classified as follows:

1. **A search for deeper meaning:** searching for an in depth understanding of self harm by talking to service users and learning about their experiences
2. **Seeing and feeling**: constructing an understanding of self harm based on what is observed and what is felt when working with people who self harm
3. **Adopting culture and practice**: adopting knowledge existing within the participant's culture, or ward culture and practice

6.4.1 A search for deeper meaning

Participants described gaining an understanding of self harm through an active search for underlying reasons for the behaviour. Staff initially struggled to make sense of self harm, but described how, in time, they were able to understand by talking to service users and learning about their experiences:

Lo8: No at first I think I really found it scary, 'cause like, you know, I never thought that a human being would actually do things to themselves to that degree or make themselves suffer, was at first I think, what I couldn't get over was the suffering bit. But the more I've spoken to people and the more that people have opened up, and the more I've read reports… you know, it's all, I think it's part of training and part of learning."

Lo3: "Prior to coming into mental health, I'd never heard of self harm. I'd never seen anybody self harm. I never knew anything about it….when I started working in mental health, it was a phenomenon I just didn't understand. I didn't understand why people wanted to do that to themselves; why they, at times, felt unable to express their pain through other emotions that are readily available and less painful, in some ways. I've been here 10 years, so I've nursed lots of different people with lots and lots of different reasons and histories and dynamics and backgrounds. So you come to really know the people individually. You spend a lot of time learning about their lives and what's troubled them, and what's brought them to the situation they're in."

These participants described being motivated to learn more about the person's experiences:

Lo8: "If anyone is doing such things I tend to want to know, like you know, what kind of background? What has happened to them and, you know, also find out from them when they come in."

This was driven by the belief that self harm can "*always"* be attributed to some unknown, but underlying issue:

Hi2: "We wanted to know more about her feelings. We were not judgmental; we were just trying to be honestly talking to her; just trying to get in-depth with her, and finding out what was causing it... You have always spoken to the person…You have that little bit of understanding of why they are doing it. There's always something attached to that patient."

Hi8: "We keep talking, that's what we do a lot of before we resort to seclusion or restraining or anything. At the end of the day, if someone is self harming there is always a reason for it, you just need to get to that reason and find out why they're feeling that way."

In these extracts Hi2 and Hi8 explain how, when working with people who self harm, they try to discover the meaning of their behaviour. Hi8 explains: "*you just need to get to that reason*". Hi2 describes the reasons for self harm not as part of the person themselves, but "*something attached*" to them. The search for this "*something*", requires getting "*in depth"*, and trying to find out "*more*". For her, there is something more to be discovered than what is already known. These accounts suggest that service users may struggle to understand their own self harm, and so staff play an active role in helping to unearth the meaning of their behaviour. Staff explained that, for this to happen, they must first

establish a trusting relationship:

> *Lo8: "I think the hardest bit is just the getting to know. So with someone new, the hardest bit is just getting them to trust you that bit more, to tell you things"*

Here Lo3 gives a detailed account of her search for a deeper meaning:

> *Lo3: "They've taught me a great deal about what that experience means to them. It's given me the ability to be able to pick out and plough around things that perhaps other people don't necessarily do. They might just see the act of self harm. They wouldn't necessarily try to get below and underneath that, as I put it, to work out what happened there. Where did that begin? What caused it? Why now, still, five years later? What does it mean to that person?"*

She uses the terms "*pick out and plough around*" and "*get below and underneath*" to explain how she is able to explore the meaning of self harm in depth. This is a skill she has developed by listening to people talk about their experiences. By explaining that this is not standard practice, that others "*might just see the act of self harm*", she suggests that other staff may not be able, or willing to do this, and so self harm is often taken at face value. For Lo3, arriving at an in depth understanding of self harm involves trying to "*work out*" why a person first started self harming, and what it means to them now. This involved not only talking to the service user, but also employing some critical thinking:

> *Lo3: "there's a lot of reflection in practising this kind of work. Unlike learning disabilities, where you go home and that will be that, when I go home, I tend to reflect on my day, and think about what could I have done differently? Or tomorrow, I want to go in, and I really want to challenge this particular subject with this patient, and I need to think about how I'm going to do that"*

This is described as a process of "*reflection*"; where staff set aside some time to consider the meaning of self harm, and how people should be supported. Lo3 and Lo2 described how they used psychological theory during reflection, to help them make sense of self harm:

> *Lo3: "So they will sometimes say to me, "Well, I was feeling bad. I couldn't talk to anybody this morning, because they were too busy. You looked like you were busy" …Sometimes I think that's about projection. I think a transference and projection occurs sometimes, where perhaps somewhere in their past, there are elements of rejection, or they have not been rejected, but have met with hostility, or, "go and deal with that on your own."*

Lo2: "I think along the lines of the ABC, which is what affects the behaviour cognition. Their mood will determine their behaviour. Then that would determine sometimes their thinking. Sometimes it would be a slightly different cycle where it would be their thinking that determines their behaviour and then determines their mood. There is always a reason why someone does something"

Here Lo2 uses a cognitive behavioural model as a framework for interpreting self harm, and Lo3 uses psychodynamic theory to explain why people self harm during times when she is not available. She does not view this behaviour as manipulative, but instead attributes it to the service users' past experiences. These were the only occasions where theory was mentioned during interviews with staff. Other staff, although lacking a theoretical framework for understanding self harm, expressed a strong belief that it meant something was "wrong":

Lo10: "To be quite honest with you I always believed there must be something terribly wrong that has happened in that person's life, to have cut yourself. I never thought they want attention, I never ever thought. Because you can get attention if you want in another way…So I always believed that there is an underlying factor. You might be aware of it, you might not be aware of it, but there must be something that is causing the person to cut themselves. Because even if you burn yourself on the stove you become so painful, it is so painful, you don't want it to ever happen again, but if you cause it yourself, to burn yourself with a cigarette or with a cigarette lighter and not feel the pain, or you feel the pain but you are still doing it, there is something that is drastically wrong somewhere.

Lo10 outlines a very strong belief that something must be "*drastically wrong somewhere*" for a person to self harm. She is unsure what this "something" is, but by reflecting on the individual's experience of the act of self harm (the overwhelming pain, or lack of pain), has concluded that this is not 'normal' behaviour. She firmly rejects the view of people who self harm as "attention seeking" which she contrasts with her position, suggesting that this trivialises self harm. Several participants described how adopting a non-judgemental view of self harm allowed them to explore the underlying reasons for the behaviour:

Lo2: "I've read about humanist principles of Carl Rogers where it's unconditional positive regard for other people. I will see the patients as humans first and patients second. I will think, "Why has somebody done this?" Rather than, "You're a patient, why have you done this?"… Very early on in my training. It was just one brief journey into Carl Rogers, how he was thinking, because obviously you look at different

theorists and he was just one. I just thought, if you're coming to mental health, you've got to come in in a non-judgmental way"

Lo3: "I think we have to be very careful not to just see what you see with people. I think you have to be very careful to not see somebody as, "That's a person who self harms," but see the person, and then, "Oh, that person actually self harms." It should be primary; it should be secondary to the person. I think unfortunately, sometimes that's not always the case…I think I'm naturally quite a reflective person. I reflect on not only my approach, but I reflect on my day and how those people are. Sometimes I'll worry about them. I think I tend to be quite a grounded person, really. So maybe that's my personality, as well as my approach. I don't know."

Here Lo2 and Lo3 give an outline of the philosophical positions that underpin their practice. Lo2 has adopted Carl Roger's principle of unconditional positive regard, which means he accepts people without judgement. He stresses it is important to "*see the patients as humans first*". This view is echoed in Lo3's account where she explains: "*it is important to see the person*" first, before the self harm. By saying "*we have to be very careful not to just see what you see",* she again highlights how it can be easy to take self harm at face value. Whilst Lo2 attributes his approach to Carl Rogers, Lo3 feels that her way of working may be part of her personality. Here, Lo2 and Lo3 acknowledge that staff can form a certain view of service users who self harm before coming to know them as a person, and that, in order to gain a deeper understanding of self harm people need to adopt a non-judgemental position. Lo8 and Lo1 explain that by seeing past the act of self harm, and talking to people about their experiences, they are then able to empathise with them:

Lo8: "they've got a better understanding, although it's atrocious for them, in the other people's eyes, it's absolutely horrible what they do, but you find that half of them actually understand certain elements of why they're actually doing this…once you get talking and they're, and they tell you what's going on with them, it's easy to manage. 'cause like, you know, when they're in a state, I can actually understand some of the reasons why they're doing it. So maybe it sits better with me"

Lo1: "Things people say because when you hear their stories and things or, even, read things but when people are talking, of course, it's more graphic. It's different because the emotion's there. It's easy to understand why people are behaving like that, isn't it? Why they see life like that, because you have probably the same. It's about being human, isn't it, it's hard. Life is hard."

Lo8 recognises that, for some people, self harm is "*atrocious*" and "*absolutely horrible*", however he feels that although the act of self harm is itself difficult to understand, the reasons underlying self harm often are not. Lo1 explains that when he talks to people about why they are self harming "*the emotion's there*", and so he finds he can empathise with how they are feeling. Although typically self harm is not part of 'normal' human experience, by saying: *"you probably have the same",* he explains that the underlying emotions are in fact something that most people will have experienced; *"it's about being human".* Participants acknowledged that trying to reach a deeper understanding of self harm can, at times, be difficult. A major issue was the lack of time staff had available to talk to people:

> *Lo8: "Because that's the other thing about this place, not having the time to actually unpick and do all this. By the time you start to unpick and things are going well, they're going home, so you half open Pandora's box, which I think is going to be more damaging than leaving it closed and just saying to them; tell me what's comfortable, but don't open the whole box".*
>
> *Hi8: "We have a psychologist on the ward who visits every now and then, so the input is there, just get the psychologist to have a word, because sometimes we're not really in the capacity to go through life with the individual."*

Participants felt that sometimes service users themselves were not able to enter into these conversations:

> *Lo1: "It's hard sometimes because people in depression; it was hard for him to say things"*
>
> *Lo8: "'Cause some people can't even talk about the reasons why they do it and if they can't even talk about the reasons why they do it, how are you going to replace a coping mechanism if you don't know the reasons, all the reasons behind that? So you find that like, you know, it's difficult"*

And that this can be quite a skilled process, so was something that staff could struggle with too:

> *Lo3: "Because you don't always know what to do. We're human beings, we don't always know what to say. We don't always know what the right thing is at that time*."

6.4.2 Seeing and feeling

Just over half of participants developed an understanding of self harm by drawing directly from their concrete experiences of supporting those who self harm. Here staff did not speak to service users about the underlying meaning of self harm, but instead went by what they were seeing, or what they were feeling. Some described observing a change in people's mood following self harm:

> *Hi1:"I felt like after he self harmed he would be, he would feel better, 'cos his behaviour and everything instantly was like, his mood would brighten up, so I just felt like ok, maybe it's just, you know, it's just a way for him…to just get, get some sort of emotions out, yeah. It's just what I've seen on the ward, you know, and like, how it looks like it helps people cope with stress or pain or, it looks like it helps"*

> *Lo1: "it is a way of their mental torment and pain - to have this released. It seems to have that effect, really, you know because you can see people cut - they don't, they're doing that* [participant tightens his muscles] *like a pressure cooker...you can see they're in not a nice place. Then, after that, it is like they are more relaxed."*

Both Hi1 and Lo1 give an account of the dramatic effect self harm can have on a person's behaviour. They have seen it come before an instant improvement in mood, and so have attributed this to self harm; "*it looks like it helps*". During the interview Lo3 actually demonstrates the physical signs of stress, to illustrate how prior to self harm "*you can see"* people are *"not in a nice place*", and then see them become more relaxed following self harm. Some staff appeared to make judgements about the meaning of self harm based on the severity of the injuries sustained:

> *Lo1: "Just making marks. Some started to bleed - not really cut but just scarring a bit. It was all red. Then I called him, "Come on, [patient name] you can't do that" and left for him to clean. Yes, it wasn't as severe as other cases I've seen. It was a way of having, maybe, some attention as well. It's hard to say, really, isn't it?"*

> *Hi2: "It was just superficial. It wasn't like lots of bloodletting, but just slight scratches. I think it was his mannerism; the way he was coming across. I think there was something he wanted to gain from this system, but it wasn't very clear, because he had a good support system"*

In these cases Lo1 and Hi2 are unsure about the meaning of self harm, but rather than attribute it to some underlying distress, suggest it was being used as a way to gain something from staff. By outlining a description of the physical act of self harm; that it was "*just*" scarring, or "*just*" scratches, and clearly differentiating these episodes from more "s*evere*" cases, for example "*bloodletting*", it appears as if these judgements are based on observations of the severity of the self harm. Hi2 spoke about this service user at length, and struggled to make sense of his behaviour because she felt there was a disconnect between what he was saying, and how he was behaving:

> *Hi2: "The way he was being admitted, he was always attempting to throw himself over the bridge. His extreme feeling of suicide and self harm was initial, but as he got to a point of safety, where he was being nursed, the same feelings subside, in a very quick manner. The team were gradually assessing him - lots of seeing and observing that he's doing well.…there was evidence that he could do well, but he wasn't actually intending to claim it; to say, "I am well, and I need to get moving again"…During the close observation, he was always, "Let me have my meals, my cup of tea," and joking and laughing; just becoming normal. I'm not trying to differentiate; it was just a totally different way of presenting of how a person has a severe feeling of self harm and suicidal ideation, and then yet, coming on and getting back to normal life very quickly, and just acting out superficial cuts"*

She explains that this person has had several admissions following a suicide attempt, however, once on the ward, his feelings subside and he quickly returns to "*normal life*". Although he maintains that he is not doing well, she describes "*evidence*" to support her view that, in fact, he is, i.e. observations of him "*joking and laughing*". In the absence of any evidence of distress, she views his self harm as "*acting out*". Here Hi2 describes this as a "*different*" way of presenting. Unlike earlier accounts, where staff believed all people who self harmed were in need of support, several participants here made a distinction between two 'types' of people who self harmed; those who appeared to be in 'genuine' distress, and others who were seen to be 'happy', and 'normal' most of the time. The latter were often viewed as manipulative:

> *Lo6: "I mean with everybody that self harm, you have to be quite firm and like, not cruel, but firm as in the sense that 'you can't do that', you know, 'why are you doing that?'…They'll open up and like, they actually, they'll give you a real explanation and over time you kind of break away at that and you can get to the reason. Whereas the other people they'll just say, they will actually say, 'oh well, you never did this' or 'you didn't do this for me and nobody cares about me at*

all'… so it's quite current and like when you observe them, with their friends they'll be quite happy go lucky and then around nurses and stuff they'll be completely different. So it's just about observing them really."

Lo7: "I think if you've had a horrible past, then you've, not an excuse to self harm, but you've got a reason. There's a reason why you're doing that behaviour. Somebody who has had a decent past, and there's nothing significant happened to trigger that behaviour, it's like, why are you doing this?"You're an intelligent girl, you've been to university. You must be able to see that there are alternative things to do with your life, other than this?"

Here Lo7 explains that she considers a "*horrible past*" an acceptable reason for self harm, and views self harm as manipulative when this is not the case. Lo3 differentiates between people who immediately "*open up*" and offer a "*real explanation*" for self harm, and those who respond by "*just*" saying they were self harming because they were not supported by staff. In contrast to earlier accounts of 'a search for deeper meaning' Lo3's appears to take people's immediate response to her questioning at face value ("*it's quite current*"), and when a "*real*" explanation is not given, she does not pursue this further but uses her observations of "*the other people"* being "*happy go lucky*" to support her view that they use self harm get to their own way. Staff not only described this lack of distress as something they witnessed, but also something they felt:

Lo7: "It's not genuine; it doesn't feel genuine. It doesn't feel like a genuine distress that they've got. I think that's the difference, it's not a genuine distress."

Participants differentiated between service users not just on the basis of genuine distress, but also whether or not they behaved as if they 'genuinely' wanted help:

Lo7: "You're doing everything you can for them; they're wanting housing, they're wanting their benefits sorting out. They're wanting to be referred to this place, and that place, and you're doing it all, and they're still self harming"

Hi1: "I used to have one to one with her and she'd cry and all that, and she'd tell me she was thinking about killing herself. But each time I sit with and I talk with her, she tells me she feels better, it passes. You see that they genuinely want help…Such people I don't mind giving them my time because I know they really, really want help and they want to change. I tell you, I see people like the other ones, the help is there but they don't want it"

Here staff reveal an expectation that service users should stop self harming when they are offered support. When service users do not respond to support they are seen to be

manipulative. One participant described how you can tell that someone is using self harm to manipulate others, by observing their general behaviour on the ward:

> *Hi3: "Some of them you can actually tell …the way they are on the ward and they probably like just demanding like in and out of the office and asking things of the staff…Yeah, some of them you can actually see"*

Because this person was "*demanding*" things from staff, her self harm behaviour was also seen as an attempt to get what she wants.

6.4.3 Adopting culture and practice

This theme describes how staff's understanding of self harm was shaped by the customs and beliefs existing within the wards where they had worked, or within their culture as a whole. One participant had never experienced self harm until she came to the UK. Initially, she found it shocking and difficult to understand:

> *Lo10: "I would love more training, and training on self harm. I feel because I have had the training in the olden days and my training in South Africa, so I only came to this country to find there are people who self harm and to me it was a shock because I had never heard it before so I feel inadequate"*

She explained that in her culture, self harm was hidden and never discussed because of the stigma associated with it:

> *Lo10: "In South Africa where I come from, maybe they self harm but they don't come to hospital because culturally it is not acceptable. So I would say myself I've never come across a self harmer in South Africa in a hospital, there may be many, many who are just out there but who will not come into hospital because they know the nurses will shout at them, the doctors are going to ignore them, they are very busy, they don't have time for people who harm themselves."*

Lo7 also felt culture was important; she believed that if staff had not been exposed to people who had experienced trauma during their life, they were likely to find self harm difficult to understand:

> *Lo7: "Some people are very stuck in old ways; it can be a very cultural thing. I think it depends where you've been brought up, who you've been brought up around. If you haven't seen people have a lot of trauma in their life, if you've led quite a sheltered life, maybe?"*

By using the term "*stuck in old ways*" she outlines how a person's cultural background can have a lasting impact on how they view self harm because they can become "*stuck*" in their initial understanding of the behaviour. She explains how these cultural influences can cause disagreements when working in a culturally diverse team of staff:

> *Lo7: So up home, the staff are very similar. They've all got a very blunt attitude, "Why are you doing it? I'll come and do it to you." Whereas down in London, it's so culturally diverse, it's hard sometimes to come to a complete understanding, an agreement or consistency, at times"*

Participants also learnt a lot about self harm from their colleagues. This was particularly important for Healthcare Assistants (HCAs), who had no previous training in mental health. Hi4, a HCA, explains that because of the fast pace within acute services, she had to learn very quickly:

> *Hi4: "I think it comes with the environment of the ward, to be honest. I think it comes with the faster pace, the different patients, different people that you meet, the turnover as well. I think you have to learn quite quickly. You learn off other people, other nurses, other HCAs."*

For her, the easiest way to so this was by observing her colleagues. Hi1, also a HCA, describes how, when she started her job, she quickly adopted the values and beliefs of the staff around her:

> *Hi1: "Cos when I, when I came here, sort of, I could see that attitude from the other nurses was like, you know, 'You don't tolerate this behaviour'. And so me joining, I thought, you know, 'I'm not supposed to do that', so I was kind of like, I could see, when someone self harms, all the staff are just sort of, 'Ignore them'. 'Cos it's like they, they just think 'Oh, she's attention seeking. I'm going to ignore them'. So I was like 'OK, so that's what you're supposed to do… So, yeah, coming here and I didn't know anything about it, I'm going to obviously, just sort of observe what's going on, and yeah, that was what was going on, so I thought that was how I was to deal with them."*

Hi1 explains that, because she had no previous knowledge of self harm, she "*obviously*" was going to learn from those around her, as this was the only way she could learn. Initially she accepted their views without questioning but after attending a training course formed her own opinions about self harm. Another HCA had only experienced one person who self harmed, but learnt about other "*types*" of people by listening to staff talk about those they had supported in the past:

Hi7: "Personally, she's the first person I'm working with, but I've heard stories about people that self harm. And most of the things I've heard is- do you understand? They don't, when they self harm, they don't come to a member of staff, or if they take an overdose, they don't come to a member of staff to say I've done it. Most of them do it, umm, between life and death situation. You know they really, really want to harm themselves... I know in their heads something is not right, something is really wrong with them"

Here Hi7 describes hearing "*stories*" which depicted certain ways in which people who self harm behave. For her, these stories represent a truth about how people who have something "*wrong with them*" are expected to act. Her very definite account of how she feels people should be, e.g. her repeated use of "they don't…", reveals that she has adopted these stories as fact- "*I know in their heads something is not right*". The person she is currently supporting does not behave in this way, and consequently she believes they have nothing wrong with them. Hi5, a nurse, had also heard stories about people who self harm:

Hi5: "'Cause I can remember, although it's not my ward, I went to do bank shift somewhere and there is this lady, female ward…and I was told like in [name of hospital] there is this place, I can't remember the ward, so they give them, they want to kind of self harm themselves, they give them like whatever they use and as soon as they've done it they feel better. So I don't know, that maybe the person, individual at that time, that particular time, probably they are doing it as a result of coping or I don't know."

She has been "*told*" about a ward which allows people to self harm because it helps them to feel better. This has led her to consider that self harm could be being used as a way of coping, although she is still not sure. Hi7 had not only drawn from stories told by nurses, but also representations of self harm in the media:

Hi7: Because peer pressure is a very very, if you're not strong you could, I've seen, I've heard, I've seen on the news what peer pressure has done to some children. They've ended their lives, you know they've really hurt themselves badly, so that would be a factor as well"

Hi2 and Hi6 spoke about how sharing knowledge within the team had shaped their understanding of self harm:

Hi2: "I never have [had training], to be honest with you. I always relate with my peers; so all my colleagues. There are two of them who have had that, and

through them, we learn…Sharing of knowledge within the team. It's very important."

Hi6: "I don't know, I think it was, we had some group meetings that the psychologist, like, you know, met and stuff, and just a bit of counselling, a bit of talking about it with our colleagues and everything, you know, just to try and understand why this person is doing it. It did help."

Hi2 learnt "*through*" her colleagues, who had been on a training course and shared their new knowledge with the team. The ward where Hi6 worked had a multidisciplinary team meeting, where they discussed the meaning of self harm. During these meetings she found the input from the psychologist particularly valuable. Two participants had previously worked on specialist wards, which admitted large numbers of people who self harmed, and felt this had had a significant impact on how they viewed self harm:

Lo4: "I didn't go on a course, but I worked on a female forensic unit so self harm was really part of it"

Lo1: "I think what made a lot of difference is to do with the experience I had in [name of hospital]. That's probably, they're community based, I had a placement there. It was very interesting; it's a specific personality disorder there"

Lo1 explained there was more knowledge about self harm within these teams, compared to the acute service he currently works in:

Lo1: It was a lot of staff; very high interest and quality about that. People wanted to go and work there; that's the difference, isn't it? They know what they're doing.

Both participants described how these specialist wards had a different way of operating:

Lo1: "It was highly structured every day from the morning to 6:00pm, when we'd have tea together. The whole group; staff and patients talking about - it could be anything…It was so good because even at lunch time, we would sit with them. So there's a lot of being together with people."

Lo4: "We had a lot of activities going on. We would go out with them, travel, trips, up to Brighton or anywhere nice, we would have fun with them, talk with them, music group, we had video nights you know where they can watch movies, creative arts as well, we had a make-up day as well where they can make their faces, you know everyone kind of share their experiences"

On these wards the day was very structured, Lo1 explains that staff and service users spent a lot of time "*being together*", Lo4 explained that this meant they shared their experiences. And so staff had the opportunity to really get to know the people they were supporting, which helped them to understand why they were self harming:

> *Lo4: "you're with them long term, so you get to understand what's going on for this particular person, each individual"*

Both participants acknowledged that this was not something that happened on acute wards:

> *Lo1: "Here, it's difficult, isn't it, because, usually - I never think we have enough staff. When it's quiet, it's nice; then we can…It's difficult. Just people are pacing around then going to the bed. It should be there [time to spend with people]"*

These participants also explained how service users would play an active part in the running of these specialist wards:

> *Lo1: "You had all sorts of different tasks from looking after the, the skills, and the pantry there because they helped ordering things, making lists and things. You have people cooking there - very nice food there, by the way."*

> *Lo4: "These activities like pop night, disco night, we had different games, they came up with the structure themselves, they came up, you know females are, they came up with the structure and they had to participate, they actually ran most of the groups"*

This all meant that staff came to see those who self harmed in a different way; as equals and as "*friends*":

> *Lo4: "Yeah that ward was like completely different, it was like completely different, it was like home to the patient, cause we don't use any containment, we're friends with the patient, we, we saw them as, though they were forensic patients, we saw them as less risk cause you know when patients are forensic it's like 'oh my god' but we didn't see them like that at all"*

6.4.4 Summary

There were three different ways in which staff constructed their understanding of self harm; searching for a deeper meaning of self harm through conversations with service users, using what they saw and felt when supporting people who self harm, and adopting the knowledge and values which existed within the wards where they work, or their

culture as a whole. Searching for a deeper meaning of self harm meant building a trusting relationship with service users, and learning about their lives. Staff spent time talking to people about their self harm, and reflecting on their experiences. These staff were motivated by a belief that there was always an underlying reason for self harm and had a non-judgmental approach which enabled them to empathise with service users. Those who based their understanding of self harm on what they observed were likely to take the behaviour at face value. Staff made very 'in the moment' judgments about the meaning of self harm at the time the harm was taking place, which meant that in cases where there was no observable signs of distress, self harm was often interpreted as being used to manipulate others. Staff described how their understanding of self harm was shaped by the values existing within their culture. They also described how they learnt about self harm from their peers. This was particularly the case for HCAs, who had little or no training in self harm. Participants who had worked on specialist wards were exposed to staff who had a lot of knowledge and experience of self harm. The way these wards were operated meant participants were able to spend a lot of time with service users, and so developed an in depth understanding of their behaviour.

6.5 Do nursing staff distinguish between acts of self harm and attempted suicide, and if so, how?

All but one participant said they used the term 'attempted suicide' to describe a behaviour which they saw as distinct from self harm. This section presents staff's views on the differences and similarities between self harm and attempted suicide, and how they distinguished between them in practice. Staff views were captured by the following themes:

1. **Going full force into it:** inferring suicidality from the characteristics of the act of self harm.
2. **Disclosing intent:** inferring suicidality from what people tell staff about their intent.
3. **A darker place:** descriptions of how people who are suicidal are in a different state of mind to those who self harm.
4. **Blurred boundaries:** where staff reveal that there is not a clear distinction between self harm and attempted suicide.

6.5.1 Going full force into it

"*Going full force into it*" was an expression used to define the act of attempted suicide. Staff believed that when attempting suicide, people did everything they could to make sure they did not survive. This meant using high lethality methods of self harm, and ensuring they were not found. This was used as a way of distinguishing between acts of self harm and attempted suicide by all but three participants:

> Lo10: *"They normally don't attempt, they normally don't wait, they go full force to it. Unlike self harming, self harm they may say "I want to kill myself" but they will make a small cut and I think there is a difference between the two, you can tell with experience which one is self harm and which is suicide attempt"*
>
> *Hi1: "I think people who end up doing, committing suicide, like, they're not really, they don't go through this long period of self harm, self harming, they just kill themselves"*

In these extracts Lo10 and Hi1 explain that there would not be a period of self harm preceding an attempted suicide. By contrasting "*people*" who end up "*committing suicide*", and those who self harm, they identify attempted suicide and self harm not only as different behaviours, but also behaviours that would not be displayed by the same person. Lo10 suggests that these behaviours can be differentiated by the type of method used. Staff described very definitive ideas about what type of behaviour constituted a suicide attempt:

> *Hi8: "We would only ever say 'attempted suicide' if the individual tries to ligature. It depends, because if it's a laceration then it's not really attempted suicide"*
>
> *Hi2: "Ligature, for example, any ligature is attempted suicide. I'm not saying it's self harm; it's attempted suicide…I would definitely draw the line. It's not self harming; it's attempted suicide, yes."*

Hi8 and Hi2 classify any act involving a ligature as a suicide attempt. Hi2 is very clear about this, however by using the phrase "*draw the line*" she reveals the often arbitrary decisions staff must make when classifying these behaviours. An attempted suicide could also constitute other methods of self harm:

> *Lo4: "And it depends on, say a patient is just superficial cut, self harming themselves, to me it's completely different, because I worked in the unit it's different, like someone who tries to hang themselves, or use the bath, or use the sheet to tie themselves-it's different, it's different."*

Hi2: "It's very clear; based on what the patient would be doing…Let's say, depending on the quantity of the overdosing. So if it was just a few, the person, we'll say, is self harming; it wasn't attempted - but if it was a quantity, then that was attempting suicide…once they've done it in that manner, that means they're really very, very intent on doing harm to themselves."

Hi4: "Yes, I think that's the difference, to be honest, the extreme. There's superficial, up here [shoulder], and then there's here and here [wrist]"

In these accounts staff describe how different acts of self harm signify different levels of suicidal intent. Lo4 contrasts different methods, whilst Hi2 and Lo4 describe a more nuanced system of classification, where there are distinct levels of harm within the same method, i.e. the number of pills taken, or the location of the cut. Lo4's repeated use of the words "*it's different*" and Hi2's explanation that this is "*very clear*" suggest that these staff are confident in making decisions about suicidal intent based on the methods used. However not all staff believed people using a high lethality method of self harm were suicidal:

Lo5: "They may think, 'I'm just self harming, I'm just going to use that as empowering myself', and cuts a vein. Which may be so severe that if they don't get immediate help, it could lead to death. But it wasn't done, or it wasn't meant for them to actually engage in any suicidal activity, you know. Whereas someone who engages in a suicidal activity, it could be, you know, causing so much harm to themselves, which they had done intentionally with that thinking, that 'if I do this, I'll end my life'…That I think, that's the line I draw between the two

Lo7: "Say if somebody had really gashed their arm open, and they could have died from that, or chopped at their legs and could have died from that, I don't think I would put that down as attempted suicide. That was meant as a self harm technique, not as intent to take your life."

For these staff intent is not only determined by the type of method used, but also whether, or not, the person was aware that it could end their life. In contrast to these accounts Lo8 believed that people using less severe methods of self harm could also be suicidal:

Lo8: "Because you've got varying degrees and we're not, we're not all supercharged to be doers. There's always a protective element, pain is one. Pain is one, so like it can be superficial but they don't deal well with pain, so it's a protective matter for them…so it's about like, you know, exploring it and talking about like, you know, why do they want to kill themselves?"

Staff revealed that the circumstances of the act could be used to distinguish acts of self harm and attempted suicide:

> *Lo1: "Not only what they are doing but the circumstances; the time when it's being done. When you think about that, they could really succeed if it wasn't – if I didn't arrive here at this time. That's quite serious, isn't it? It's not just a cry for help…For example, when people are having handover that you have less people on the floor. If you know that - because the patients, of course, know. They know when there are less staff around; the middle of the night, you'll not see as much."*

> *Hi7: "Then she will go to the bridge and she will walk in front of the camera until the police notice her. And then when the police come, you say what happened to her that she broke her leg, it was by accident, you know she didn't want to jump. She held them, it took the police and the fire brigade a lot of time to come in, so because her hands got tired, she couldn't hold them anymore and that was why she fell."*

For Lo1, the precautions a person takes to ensure they are not discovered by staff can indicate whether the act is an attempted suicide, or self harm. He explains that an incident of self harm during handover is more likely to be an attempted suicide, than if it were at another time when more staff were around. Hi7 describes someone who fell from a bridge and broke her leg. Despite her injuries, Hi7 does not believe she was suicidal because she walked in front of the police camera, and so knew people were aware of her actions.

6.5.2 Disclosing intent

This theme describes participant's views on how suicidal intent can be determined on the basis of what people do, or don't, say during conversations with staff. Several participants did not always believe what people told them about their intent:

> *Hi2: "Yes, I wouldn't go by what they are saying [saying they are not suicidal], because that's when it's more risky, you see. That's when they are trying to mask it; when they are trying to hide it…If they're saying it [saying they are suicidal], that's a cry for help, because the fact that they're saying it, that means they want someone to intervene."*

> *Lo10: "Sometimes we get patients who are referred by police here, some of them, most of the self harmers, ask for help. They will go to a bridge and call for help,*

and go to anywhere they can try to kill themselves and they will call for help. Whereas suicidal patients, they will normally behave quiet, they don't talk much, they make their plan and they make it."

Lo5: "Most people who commit suicide, it's, they do it in a clandestine way. They don't talk much about it. They may do some activities which may give an indication that this person actually meant to kill themselves. But people who, maybe, who come to the hospital, to the general hospital, and say 'oh I'm having these thoughts of suicide', it means they are not actually going to do it, but they are just having the thoughts, it's not something that they intended to do."

Here, again, by contrasting "*suicide patients*" and "*self harmers*" staff present self harm and attempted suicide as behaviours that are carried out by different 'types' of people. These people can be distinguished by what they reveal during conversations with staff. Staff explain that when people seek help it "*means they are not actually going to do it".* Contrastingly, people who intend to take their life "*behave quiet"*. And so, paradoxically, those who actually express suicidal thoughts are not considered to be suicidal. Other staff however, did go by what people told them:

Hi8: "I wouldn't say attempted suicide unless the client said to me, "I want to kill myself", then I'd use the term 'attempted suicide' because at the end of the day, always go on the client's word."

Lo3: "Sometimes a patient will tell you themselves. Sometimes, if they regularly self harm, they'll come and say, "I'm not feeling very safe today." That, to me, is an indicator that it's not a normal day… so you need to be a bit more aware on this day…sometimes, when they come to me and say that, I think they want me to help them to avoid it, because part of them doesn't want to, because they know it's not going to be safe. It's not going to be a comfortable situation"

Unlike accounts above, Hi8 believes staff should "*always go on the client's word*". Lo3 explains that when people who self harm approach her and ask for help, rather than deciding they are not suicidal, she takes them seriously. Because they are asking for help, she believes that "*part of them*" does not want to die, but equally, feels that there is a part of them that does.

6.5.3 A darker place

Many participants believed that people who attempted suicide experienced a different state of mind to those who self harm, describing this as "*a darker place*":

Hi3: "So I suppose there's a difference between their mental state. Sometimes you can just pick it up and we'll be able to do something"

Lo3: *"She would self harm, again, like we were talking about, in the process of her day to day living…When she was really in an emotionally distraught, dark place, then she would go all out, and it would be a suicide attempt."*

Lo5: "Well, with suicide, it's different from self harming. With suicide it's with someone who is very distressed and has expressed thoughts to kill himself and is subjectively and objectively very depressed and has given up on life"

By contrasting the experiences of people who have attempted suicide to those who have not, these participants emphasize that those who are suicidal are seen as being in a different "*mental state*" to people who self harm. People who are suicidal are believed to be experiencing more severe levels of emotional distress. Lo3 describes someone who frequently self harms, but can switch into a suicidal state of mind, which means she becomes "*emotionally distraught*". Hi1 explains that people who are suicidal are different from those who self harm because they never seem happy:

Hi1: "Cos there's some people who are like, very happy or very sad, on a ward. People like that I wouldn't really say they wanted to commit suicide…but I mean, there's some people who you can see have real problems, with real, you know, and they're not, they're not up and down, they're just, just down."

Further reinforcing the differences between people who are suicidal and those who self harm, she explains that people who attempt suicide don't know how to release their emotions:

Hi1: because I think that they don't really want to or really don't know how to release their, their sad emotions, so that's what I think brings them to do something like that, whereas someone who self harms they, they are releasing all the time, releasing, so, yeah"

Two members of staff however, described how a person's mood could improve immediately before they attempted suicide:

Lo10: "With the suicide ones sometimes they come and seem very depressed, very low in mood, uncommunicative and then all of a sudden without anything before the medication kicks in they become bubbly, happy, you become worried that they've got a plan or they know they're going to do it so they're happy they are going to, those are the patients we keep an eye one"

Hi7: "Do you know, umm, there's a colleague from another ward, she came here to do a shift, and umm, she was telling us, she was telling us about a patient on her ward who umm… took his own life. It's somebody who is all cheerful and all that, everybody thought, he went out on leave, came back, went into his room, went into the bathroom, and slashed his wrists, and he bled to death"

6.5.4 Blurred boundaries

Almost all staff described self harm and attempted suicide as being two distinct behaviours, yet during their interviews, many reveal that there is actually no clear boundary between them. Hi5 explains that, although these acts are different, she does not view them as completely distinct:

Hi5: "If it's suicide, suicide is different from self harming. But altogether it's still self harming if you can kill yourself, commit suicide, you're one way or the other, harm yourself, so I don't know. It's something a bit different, but they're all the same umbrella. One umbrella."

By using the term "one *umbrella*" Hi5 suggests that self harm and attempted suicide are two different forms of the same type of behaviour. Both involve causing harm to one's self, and so "*altogether it's still self harming*". Because of difficulties in distinguishing between these acts, Lo6 explained she never used the term 'attempted suicide':

Lo6: "I wouldn't say attempted suicide. I'd say self harmed or, I wouldn't say that they attempted suicide. 'Cause I think again that's a very personal thing, and what one person, it's a, what one person may interpret it as "you tried to commit suicide" and one, another person's completely different, and that might make the person feel something else. They may feel terrible that somebody may think, 'oh they think I'm trying to end my life, but I'm just trying to harm myself because of, whatever factors'… I think we'd just stick with self harm. I've never really, I mean I've been here for three years, I've never really heard anybody say they've attempted suicide"

Here Lo6 highlights the problems faced by staff when trying to define what is a "*very personal*" experience. By saying: "*that might make the person feel something else. They may feel terrible…"* she implies that the term 'attempted suicide' carries with it certain implications, which if mistakenly used, could have a negative impact on the service user. Lo7 explained some of the consequences of labelling a behaviour as an 'attempted

suicide':

> *Lo7: "I think especially for the future, because if you document someone has made a suicide attempt in their risk assessment, you're branding them for the future. You're giving them a name, "She has tried to take her life". In the future, people become very scared. Services, I think, become very over protective and that's when there comes all this massive chaos around people"*

Here Lo7 the word "*branding*" to indicate how documenting a behaviour as an attempted suicide can have a very permanent impact on how a person is viewed in the future. She describes how, because it indicates a very high level of risk, the term 'attempted suicide' can provoke a strong reaction from staff: "*people become very scared…very over protective".* By describing a "*massive chaos around people*" she implies this can disrupt nursing practice. She later illustrates how the same incident can be described in two different ways:

> *Lo7: "I think the likes of lying on your bed and tying tights around your neck the day that you're getting told you're going to be discharged, I think sometimes they worded it that "she attempted to strangle herself in an attempt to take her life." When really, I think it could have been worded differently: "She had just attended ward round and been told of her impending discharge. She was upset, and went back to her room and she was found with tights around her neck."*

She believes that, in this case, staff should avoid describing the incident as an attempted suicide because of the implications it will have for both the service user and the nursing team. Several participants described how it can be difficult to distinguish between acts of self harm and attempted suicide:

> *Lo3: "It was quite a severe injury, albeit that it was unclear whether that was an actual suicide attempt, or whether it was an expression of her pain and unhappiness with what's going on emotionally and psychosocially for her at the moment."*

> Lo9*: "Strange isn't it? Nobody was really sure that it was self harming. Is this self harm? Is she really feeling suicidal? Everybody was confused."*

This can be because the individual themselves may not be clear as to what their intent is:

> *Lo2: "They might have had an argument with their partner and they've decided at that moment in time that life isn't worth living. It might be that they're in two*

minds – will I actually kill myself or will I just go far enough that actually I'm harming myself seriously but not killing myself? That's where it's hard to make that distinguishing difference"

Lo2 uses the term "*two minds*" to explain how one person can both be suicidal and uncertain that they want to die. Although many staff maintained there was a clear difference between these behaviours, there were inconsistencies in their accounts which revealed that things may not be as clear cut as they claimed:

Hi2: "It's very clear; based on what the patient would be doing. Let's say, depending on the quantity of the overdosing…So if it was just a few, the person, we'll say, is self harming; it wasn't attempted - but if it was a quantity, then that was attempting suicide. That was really an intention to kill themselves

Here Hi2 initially gives a very definitive account of how, during an attempted suicide, a "*quantity*" of pills would be taken. However, later explains that people may only take a small number of pills when attempting suicide, because they do not have access to more:

Hi2: "That could be something circumstantial, like they didn't have enough to kill themselves".

In the same manner, Hi8 starts out by saying acts of attempted suicide are by ligature only:

Hi8: "We would only ever say 'attempted suicide' if the individual tries to ligature"

Yet later reveals that "*cutting certain places*" could also be considered a suicide attempt:

Hi8: "There is a risk to life generally with self harm, but it's just when it escalates to, maybe, ligatures and cutting certain places that you know will actually end your life."

In this extract he also says that self harm "*escalates*" to an attempted suicide, which suggests that the behaviours are closely related. Similarly, Hi4 initially claims these acts are "*very different*", but later describes them as being "on *levels*":

Hi4: "I think they are very different. I think that self harm is a form of release.

Hi4: "I think it always goes on levels. I see it as levels… she had self harmed over the years. It increased to ligaturing, and I think that was a serious attempt."

Here she describes how self harm "*increased*" to ligaturing. Although maintaining that attempted suicide and self harm are distinct, by using this type of language, Hi8 and Hi4 suggest they are part of a continuum of behaviours; where attempted suicide is an escalation of self harm. Lo5 expressed a similar view:

> *Lo5: "Maybe the reason why I looked at it in the sense of self harm, is that suicide attempt does not come by straight away, it has to, it's a process to me, it's a process and that process has to start from self harming."*

By explaining the process "*has to start from self harming*" Lo5 implies that all people who attempt suicide have previously self harmed. Hi4 gives an account of someone who attempted suicide after trying to stop self harming:

> *Hi4: "He's a self harmer as well, but he was trying to control his self harm. But because he was trying to control his self harm, he then attempted an overdose. Fortunately he didn't manage to get many [paracetamol] in his system once the bloods had been taken etc. Yes, so I think it does lead to other things more potentially harmful and risky, and I don't think they realise sometimes."*

Again, here, self harm is described as leading to a suicide attempt. Lo3 gave a detailed account of what happens when self harm escalates to an attempted suicide:

> Lo3: "*I've recently had a client - actually, the patient is still on the ward - who does have a history of self harm, but sometimes the self harm is more of a suicide attempt, and not entirely just self harm…Some of our patients, yes, I would say that it goes beyond self harm to a suicidal attempt…I said to her, "I'm glad I was hot on your tail." She goes, "I'm really glad you were hot on my tail as well." So she knew that she'd got out of control; that emotions or impulse, or whatever, at that moment in time, had taken hold of her, and if I hadn't been, she probably would have died…That sort of unleashed abandonment; fleeing, it's just so risky, because people very easily cause themselves serious harm in that split second, where all emotions and everything's loose, and nothing's in control".*

By saying "*the self harm is more of a suicide attempt"* Lo3 suggests that, rather than being completely separate, these behaviours can exist to varying degrees within the same person. Here, again, the suicide attempt is described as an escalation of self harm: "*I would say that it goes beyond self harm to a suicidal attempt*". Lo3 uses the term "*unleashed abandonment*" to describe the conditions under which this can happen. Unlike other accounts of people who either are, or are not, suicidal, she uses the words "*fleeting*" and "*spilt second*" to illustrate that someone can move into this state of mind

very quickly. Her account of the conversation following the incident suggests that people can also recover from it just as quickly: *"I'm really glad you were hot on my tail as well."*

6.5.5 Summary

All but one participant viewed self harm and attempted suicide as distinct behaviours which were differentiated by the features of the act itself (going full force into it), what people disclosed to staff about their intent (disclosing intent), and the individual's state of mind (a darker place). Acts which were high lethality, and which occurred during a time or place which meant it was unlikely that the person would be found, were generally classified as an attempted suicide. One member of staff, however, believed that low lethality episodes of self harm could also be a suicide attempt and some felt the person had to understand that the act could end their life. People who were suicidal were seen to be quiet and secretive about what they felt, and so many staff believed that if a person told them they were suicidal, it meant they were not. Staff believed that people who were suicidal were more distressed than those who self harmed. Although many staff maintained that there were clear differences between the two behaviours, there were contradictions in their accounts which revealed that things may not be as clear cut as they claimed. A number of staff described self harm and attempted suicide as being different levels of the same behaviour. Whilst some described self harm and attempted suicide as occurring in different 'types' of people, others believed that suicidal feelings could fluctuate within a person, such their self harm could escalate to an attempted suicide. Some participants believed that staff should use the term 'attempted suicide' with care, as it can have a very permanent impact on how a person is viewed in the future, and can provoke high levels of anxiety within the nursing team.

6.6 What are nursing staff's views of harm minimisation practices?

This section presents staff views of harm minimisation, a relatively new approach, where people are supported to self harm during an admission. Of the eighteen staff interviewed for this study, four were currently implementing harm minimisation practices, nine had some knowledge of harm minimisation, but no direct experience of it, and five had never heard of the approach. There were mixed views of harm minimisation amongst participants, although all who had adopted the approach felt that it was beneficial. Three themes emerged from interviews with staff:

1. **Managing risk:** staff views about how a harm minimisation approach may, or may not, put service users at risk.

2. **Roles and responsibilities:** discussion of how staff perceived their role in supporting people who self harm, and whether they were responsible for preventing people from harming themselves.

3. **Implementing harm minimisation:** where staff outline how harm minimisation practices are implemented on their wards.

6.6.1 Managing risk

This theme describes participant's views about the risks involved when implementing a harm minimisation approach. Two thirds of participants were concerned that harm minimisation would put people at risk of serious harm:

> *Hi8: "If it was allowed to spiral on and it was getting out of hand, I would be very worried. You can only self harm in a few places. Once you're done with your arms what's next? That's the scary thing"*

> *Lo10: "It would be difficult for me, I'd be scared that they could die, they could bleed out and die."*

> Lo5: *"If someone has started by just having lacerations, maybe from an early age, or from any age in fact, after a certain while, that is not going to be sufficient for them to really feel that they, to really feel empowered they will have to increase the damage that they are causing to themselves, you know."*

> *Lo4: "Like the razor, the knives, cause when they see it they want to use it. That's my experience of it. That's my experience, cause once they have it and they feel like that they just want to use it, just cut themselves…So when they have it and they think 'oh self harm is free' I think they'll self harm more. They'll ask for knives, cans, razors, I think it would increase it"*

Many participants believed that a harm minimisation approach would lead to an increase in the incidence and severity of self harm. By comparing self harm to an addiction, Lo5 explains how over time, people will need to use more risky methods to get the same effect. Many felt that this could put people's lives at risk, and so found the prospect of a harm minimisation approach very "*scary".* Whilst staff found this difficult to contemplate, Lo2 recognised that service users may not perceive risk in the same way:

> *Lo2: "I think in my head I'm feeling this is high risk. At the same time when we see people that self harm, often they don't consider it as a high risk event. They consider it as just something to relieve themselves. It makes them often feel*

better at that moment in time. Would they need to be on continuous observations?"

Here, by saying "*in my head*" Lo2 highlights how his perception of the risks associated with self harm differs from service users'. Considering self harm from the service user's perspective, leads him to question his earlier assertion that people with a harm minimisation care plan would need to be continuously observed by staff: "*Would they need to be on continuous observations?"*, and in doing so suggests that his own perception of risk may be inflated. Although he recognised the potential benefits of harm minimisation, he voiced concerns about how it would work in practice:

> Lo2: *I've never been to a ward or any service that allows it. I've heard about it and I think theoretically it's a good idea. I suppose the issue is how tight their control is going to be and is someone going to have to be present at the time when the act occurs…It would have to be pretty well controlled even if they were about to do it without supervision, it would still have to be rigorously controlled."*

Lo2 believed staff would need to manage the risks involved by controlling the level of self harm. Hi8 and Lo3 also thought this was important, but questioned whether it would be possible:

> *Hi8: "If we had 15 clients at the same time and we've got one who is allowed to self harm, and we have to check on the client regularly, how do we measure the scale of self harming that they're allowed to do? Where do we stop, where do we draw the line?"*
>
> Lo3: *"How do you assess who's going to be safely doing that and who isn't? Some of the people we have who self harm, they are very, very serious. They're absolutely fine one minute, and the next, you're calling an ambulance…I think it would require the teams together, and really discuss how they felt about that, and whether they feel it's plausible and viable in this environment. If so, how do we determine who fits that criteria and who doesn't?"*

In order to keep service users safe, these staff felt they would need to assess the "*scale*" of self harm, so that people who were seen to be high risk were prevented from self harming. They felt this would be difficult to predict, and were unsure about the criteria by which service users, or specific self harming behaviours, would be judged as low or high risk. There was, however, some agreement amongst staff that ligatures or overdoses were very high risk, and so people using these methods should not be included in a harm minimisation programme:

> Lo2: *"Or if they're thinking of using ligature, it depends on how far they push it really. That's the difficulty, is that there aren't that many safe ways of self harming, particularly if it's with reference to ligatures or taking overdoses. I think with the cutting, I think there are ways of having a controlled environment where you could have self harm minimisation."*

Participants also felt that acute wards may not have enough resources to provide adequate support if people did seriously harm themselves:

> *Lo7: "At the moment, we've got 5 staff per shift, and we feel stretched anyway, having 5 staff to 18 patients, who are extremely unwell. So I think if you had a lot of people who are self harming and you had a lot of people safe self harming, allowed to self harm in their rooms, where we know it's actively taking place. Then, two or three cut too deeply, have you got enough staff to be able to deal with that, while you've got all these other extremely unwell patients on the ward?"*

One member of staff felt that a harm minimisation approach may also put other service users at risk:

> Hi8: *"Where does the client, identify a place of self harm for the client, would it be their bedroom? It might start occurring in public areas where other clients aren't used to that."*

Despite these concerns, many participants felt harm minimisation could reduce the risks associated with self harm. Firstly, because providing people with clean tools would minimise infection:

> Hi4: "*If it's controlled, and it's a clean blade, and it's managed afterwards, and wound care is put in, and it's clean, and it's steri-stripped afterwards, then you wouldn't get the incidents where people are finding – well, anything. It could be from a pen, crunched up, or at Christmas time a bauble off the tree. It could be a cup, a plastic cup. Then you think to yourself, "Well, why can't they have had...?"*

> Lo1: "*I think it would minimise all sorts of things; infection, cutting, whatever. So it's clean instruments; they have that release of pain. I think, also, after, they clean themselves and things"*

And secondly, because they believed it might reduce the incidence and severity of self harm:

> Hi4: "*Never. I've never worked on a ward where that has been allowed, but I think that it would actually restrict and reduce a further escalation. Because in my*

experience, again, I've found that self harmers then go to almost the next level, which is ligaturing and more – just more dangerous. I think if it's kept at a level, and it's managed at a level, why not let it happen?"

Lo3: "It would be like taking an alcoholic's drink away from them, and saying to them, "Now go cold turkey for the next 24 hours." With some people, that desire is so intense that by taking away their stuff, you make it worse, because they find other ways to harm themselves; less safe ways, more risk of infection, potentially, causing ways. Or worse still, by other means that are even more, if not more dangerous.

These extracts contrast with earlier accounts where staff expressed concerns that if people were permitted to self harm, the behaviour would escalate. Again similarities are drawn between self harm and addiction, but this time to explain why preventing self harm may cause it to increase. Those with experience implementing harm minimisation practices found that it did indeed reduce self harm:

Hi2: "*We had that plan, and it worked, because over a gradual period of time, I think we observed that the frequency of her self harming was less. Within two, three weeks, she didn't come for it [self harm kit] as often*"

Hi6: "*We just thought 'let's just try and see if it works' so it was like, after maybe about a couple of weeks of having these meetings we thought 'let's just try and see if it works' and it did, it did work."*

Another benefit was that people were able to learn how to harm themselves in a safe way:

Hi6: "*Cause the thing is, if someone is self harming, even if they're discharged, they'll still do it at home, so if you continue to advise them that when they feel the urge they can at least do it safely. Then maybe it can, if they relapse when they're at home, they would still self harm anyway but might just do it safely."*

6.6.2 Roles and responsibilities

This theme captures participant's views of their role in supporting people who self harm, and whether, or not, they were responsible for preventing people from harming themselves. Many staff felt the harm minimisation approach was at odds with some of their core beliefs about nursing practice:

Lo10: "We are here as nurses, we are here to talk to patients, to calm them down, so I will feel like I've let the person down in a way if I end up saying "here is the blade go and cut yourself" I don't think I'd be able to do it. No, no, no, no, no, no. I think it would be cruel for me to"

Lo5: "I mean to me it's professional neglect because we as nurses, it's one of the things that we always have to adhere to, that it is in the interest of the individual, prevention of harm, harm to self and to others. So if that person is engaged in an activity which can result in harm then it's basically, you have neglected your own duty, you know."

By identifying themselves "*as nurses*" both participants highlight how harm minimisation challenges a fundamental part of what it means to be a nurse. By using the phrases "*let the person down*" and "*professional neglect*" these staff underline their responsibility to care for service users, and protect them from harm. They believe that allowing people to self harm would mean going against the ethical code of conduct underpinning their practice. Several participants voiced concerns that they would be held responsible if someone under a harm minimisation care plan took their own life:

Lo3: "I think that we should be open to that idea. I think there would be a whole lot of politics and bureaucracy that would get in the way of that. I think if we didn't have to have this culture that we do in all employments now, but especially in our area, of, "Well, why didn't you do this?" Or, "Why didn't you stop that?" Or, "What should you have done differently?"

Lo5: Even policy wise I think it may not be right because if that person ends up killing themselves, you then have an investigation to go through and people will be dragged into it who knew and what are you going to say? 'Yes, I saw him harming himself, but at first it was only in a controlled environment, and in a controlled way'"

Harm minimisation was not only seen to jeopardize the role of the nurse, but also the hospital:

Hi1: "Cos it's in a hospital, you know. I think that the reason why, the one reason why a person might be in hospital, for self harm, is to sort of prevent them from doing any more danger to themselves. So it's encouraging them to do that, you know, it's not really, they, they might as well not be in hospital"

Hi3: "I suppose they come to the hospital is to help them to stop doing something like that as well, and then they can get discharged and just you know lead a normal life without self harming, but if you just let them do it all the time I don't see them being able to stop."

Here the hospital is defined as a place of safety and a source of support, which, for these staff, is in direct conflict with the prospect of allowing people to self harm during an admission. Hi1 explains that if this were adopted, the hospital will become redundant; "*they might as well not be in hospital".* In this extract Hi3 supports her view that the hospital should be responsible for stopping people from self harming, by arguing that people do not have the capacity to stop themselves. Similarly, by stating that harm minimisation would be "*encouraging*" people to self harm, Hi1 suggests that people who self harm have a lack of control over their behaviour. Several participants described harm minimisation in this way:

Hi5: "I think it's encouraging them even more. But again if that is what makes them feel better or, I don't know. But to me, I don't think, I wouldn't judge, but I don't think, you're kind of promoting what they are doing. You are kind of encouraging them."

Lo6: "Erm, I suppose in a way it's giving the client the control over themselves and their own care. But then, when will it stop? And will there ever be anybody there to say, you know, 'you shouldn't be doing that. You can't do that. You can't live your life harming yourself in that way'?"

Lo5: "Obviously, self harming, which ever nature, as soon as we regard it as a self harming activity or behaviour, it will not be tolerated"

Here staff present themselves as having a responsibility to teach service users that self harm is wrong. They use language such as "*it will not be tolerated*" or "*you shouldn't be doing that*", which suggests a paternalistic approach to supporting those who self harm. In contrast to earlier accounts, participants appear to object to harm minimisation on moral grounds, i.e. what is considered right and wrong behaviour, rather than ethical concerns regarding nursing practice:

Hi8: "At the end of the day, outside in the community, if you saw someone doing that on the road you'd be very scared for them and you would approach them or call the police and say, "My God, this person is really doing some damage to themselves". "Stop that, don't do that." That's the general approach"

Hi1: "But I mean, you know, self harm is obviously, I don't think that's a reason for people to self harm, because they're upset, or you know, have a spot of, that's not a good enough reason for me."

Hi5: "I don't think so by harming yourself it helps you to cope, no I don't think so. That is not the way of coping, 'cause at the end of the day, you're going to destroy yourself. So I don't think it's a way of coping at all. There are other ways to cope"

A further issue for staff was the emotional impact it would have on them if they were expected to watch people hurting themselves:

Hi5: "Even if that is how the person copes, but at least I need to help them, you know…I'm telling you I'd never feel at ease, you understand? I'll never feel at ease…To me, I don't think I would be able to stand, stand it. Yes. So I can't even work in such environment, because I am too emotional when it comes to that, yeah"

Lo10: "Whether I agree with that – no I don't agree with it. I don't think I can be brave enough to stand and watch when someone is cutting themselves…I know everybody has got responsibility for their own care and for their own feelings and their way of coping but I think I will, if it happens here I will accept it, but I will have to be strong to cope with it"

Whilst acknowledging that self harm can be a way for people to cope with distress, both Hi5 and Lo10 explain they do not agree with this practice because it would be detrimental to their own wellbeing. Although many participants believed it was their responsibility to prevent people from self harming, at some point during their interview, they acknowledged that in practice this was not something they were able to do:

Hi8: "I don't think you can ever really stop. You can't ever change a person – this is my philosophy – you can't ever change a person because a person will only change when they want to, willingly. You can't force a change, it just doesn't happen. It comes naturally."

Lo10: "To be honest with you, when somebody wants to cut, they want to cut. And they will use all the tricks in the book to get away from you".

Lo5: "You cannot take it away from them. You can't, even if you try and prevent them, but if they want to self harm, they will do it because they know it is only one of the things that you cannot stop. If they have a chance, you can't stop them from doing it."

And so participant's earlier descriptions of their role in supporting people who self harm; i.e. to stop them from self harming, seemed to represent an ideology of nursing care, rather than the reality. Using the metaphor of a "*tool belt*" Lo3 questioned whether staff actually had the skills to help people to stop self harming:

> *Lo3: "Do we have enough tools in our tool belt - and I say that metaphorically, and I always refer to my tool belt - do I have the tools in my tool belt to be able to help somebody to change their view about self harm; help them to change the fact that they self harm? I don't know if I do, really. I don't know if any of us do."*

She believed a harm minimisation approach would be beneficial for service users, yet recognised it would be challenging for her to implement:

> *Lo3: "I need to step back, and I need to not feel that I've got to swing in there and help them, or be like a helicopter parent, and just go in and say, "Are you okay?" I think I would have to make sure that I talked to myself, and told myself to step back, and remember that that's their choice and they're an adult."*

Here she describes a conflict between what she believes is best for service users, and her own need to protect them. Again, it there is evidence to suggest that staff take on a parental role; by using the term "*helicopter parent*", she implies that staff can at times be over protective and controlling. She recognises that it would take an active effort on her part to "*step back*" and allow people to take responsibility for their own behaviour, but is willing to do so because she feels it is in their best interest. Those who had implemented harm minimisation practices gave accounts of how they had learnt to accept self harm:

> Lo8: *"You know, it's odd, but it works for them, and one of the things I always say to people, you know, if you can't replace somebody else's coping mechanism, don't mess with it. Like, you know, you're not going to be in their shoes when they're experiencing what they're experiencing, so unless you can find them an absolutely brilliant alternative then, do it, but like if you can't, then it's very difficult... it's all, I think it's part of training and part of learning and also part of your acceptance that, you know, you're only as good as the person who lets you do the interventions... so really you just have to accept it, but it takes time to learn, it just takes time"*
>
> *Hi6: "When I started, I felt I mean, when I did really, you know. You just feel a bit resentful to think…'don't they see the scars you know like all over their hands and sometimes all over their legs as well' you think I mean, why is this person*

doing that? Yeah, so, but in the end you just have to know that there's nothing you can do, you can only advise them to do as you say, minimise their self harm"

Both staff recognise that self harm is not something that is easy to understand, but describe how in time, they came to believe that nurses should not try and control it. Lo8 stresses that nurses cannot force people to accept help: "*you're only as good as the person who lets you do the interventions".* By saying "*you're not going to be in their shoes*" he explains that staff cannot fully understand the experiences of people who self harm, and so should not make decisions for them. In doing so, he believes staff are taking away an effective "*coping mechanism*". Several participants who had not implemented harm minimisation believed that allowing people to take responsibility for their self harm could be a good thing:

Lo2: "If you take that control away from them it's almost like you're making the decision for them, their thoughts are slightly being tampered with… It is a difficult process of knowing do you intervene when actually the programme itself might be getting them to reflect"

Lo2 felt that allowing people to self harm on the ward would give service users and staff an opportunity to explore the meaning of the behaviour. He also believed the restrictions placed on people in order to prevent them from self harming could be seen as punitive:

Lo2: "I think that they feel they're being punished afterwards when it's been discovered. They feel that lots of normal things they do on the ward or off the ward are actually being taken away from them. It's like a double whammy where they've harmed themselves. They feel bad about themselves and now you've removed any freedom from them as well."

Lo3 felt that stopping people from self harming could be an infringement of their rights:

Lo3: "I think we have to acknowledge an individual's need and sense of self. If that person needs to do that for whatever those reasons may be, and they want to do that for whatever those reasons may be, who, really, are we to stop them? We've got no right to tell people what they can and can't do. I know the Medical Health Act says that we can, but that's not always used appropriately."

Those who had implemented harm minimisation felt that it had a positive impact on people's wellbeing, because it meant they felt accepted:

Hi2: "he never told any of his family who actually knew him. They never knew about the self harming behaviour. You can imagine, it's a secret, and it's a guilt

feeling, of course; something that he doesn't want anyone to know, because he might be excluded and not accepted. So when he felt accepted, that had a very positive reaction within himself that really made him decide, "I'm going to take this decision."…that's when he started showing his motivation and all these plans…he was a different person totally."

Here Hi2 explains how harm minimisation can be a way for staff to show they understand, and accept an individual's need to self harm. By reducing a sense of stigma associated with the behaviour, and fostering a feeling of acceptance and belonging, it had a therapeutic effect. She believed this had a very powerful impact on service users' wellbeing, and so played an important role in their recovery: "*that's when he started showing his motivation and all these plans"*

6.6.3 Implementing harm minimisation

Four participants, working on two wards, had implemented the harm minimisation approach. This section summarises what they said about how, and why, it was implemented. Staff on one ward (ward 1) were advised to adopt a harm minimisation approach when they consulted a psychologist during a time where there was a lot of people self harming on the ward:

Hi6: *"It was about 4 patients who were doing it and it's like they were copying each other. If someone self harms, one of them wants to do it more…and we just felt like it was getting out of hand. So that was when we got the psychologist in and she gave us that advice, I think it was about 5 years ago or something."*

On the other ward (ward 2), two members of the nursing team learnt about the approach during specialist training, and later suggested it should be implemented:

Hi2: "so negotiating on how we can introduce particular care plans based on providing that kit. That was from one of my colleagues who had the specialist training."

Both teams decided to adopt a harm minimisation approach because they were unable to prevent people from self harming:

Hi2: "We had to support her, because there was nothing we could do, and she was helpless, based on her feelings, and how she was presenting."

Lo8: "When staff stop that particular person, you find that the next time she'd do it even worse. So, you know, it was a really, you couldn't win. So if you tried to

intervene and stop, it's only likely to happen, the next one will be twice as worse and also the behaviour that happens prior to the self harming would linger on...And then like, even if you do give medication and you go through the whole de-escalation route it does not work until they are actually done what they wanted to do, then they will get the relief. And you find that it was actually better than the PRN. So you're left wondering, what do you do?"

Lo8 explains that not only were staff unable to prevent this person from self harming, they were also not able to provide her with a way of relieving her feelings which was as effective as self harm. In fact, preventing her from self harming meant that her self harm became more severe. Lo3 explains that in the face of self harm, the service user was helpless, and so were the staff; "*there was nothing we could do*", and so felt there was no other option but to accept that she needed to self harm; "*we had to support her*". In such a situation these participants were able to accept a harm minimisation approach. Others however, did not find this so easy:

Hi2: Let's say, as a team, we accept there is - everyone has to agree with that plan, because at a certain time, we had, I think, one member of staff that was not really going for that, because according to their understanding, they felt it was wrong to give a patient who self harms a sharp. Just imagine."

Hi6: *"I mean some of the nurses were against it, initially I was against it, I thought that we, 'what is my practice if I'm just letting someone self harm?"*

On both wards, staff went through a lengthy process of consultation, involving a number of meetings with the nursing team and a psychologist, to discuss the new approach:

Hi2: "*I think on the third session with [the psychologist], we broached the subject, and I think we just made it clear that this is an issue. So after relating, or making it as a group discussion, and seeking help from a psychologist helped, because that person then was involved in that group discussion. So actually, they got it, so it worked… We were trying to brief everyone at the same time, so everyone could understand that it's not their doing; they can't help themselves. As nurses, we are here to support them, and to ensure that everything goes well."*

Hi6: "*I suppose it's just being listened to, you know talking to the psychologist, just being listened to and knowing how the person understands how you're feeling and just giving advice that you, sometimes, there's nothing you can't do about it."*

During these meetings the rationale for the approach was explained, and staff had an opportunity to voice their concerns. Hi6, who initially felt it was wrong to allow people to self harm, explains how this helped her to accept the approach. On ward 2 staff began to accept the approach once they could see that it worked:

> Lo8: "*We're all different, staff are different. I can stand there and happily watch, it doesn't bother me. But other people who don't have the experience will look at it in a different way. So it's also about attitudes and about people accepting what works, and showing people the evidence"*
>
> *Hi6: "You know, we just thought 'let's just try and see if it works' so it was like, after maybe about a couple of weeks of having these meetings we thought 'let's just try and see if it works' and it did, it did work."*

On ward 1, staff did not implement harm minimisation until they had agreement from the whole team:

> Hi2: *"It was a team decision. That's what I'm saying; if you haven't got a team agreement, that it seems - especially those in implementation, a new strategy doesn't work. It's a peer-ship thing. It just collapses…you need to discuss it with all your team, and come as an informed, agreed decision."*

Contrastingly, not everyone on ward 2 was able to cope with self harm, so the workload was organised to ensure that those who found it distressing did not have to witness it:

> *Lo8: "'Cause at the end of the day I didn't get to this point in one stroke, it took years to build, so I'll never actually say, 'everybody has to do it', 'cause at the end of the day, I don't want, you'll actually find that some staff will end up with problems themselves…If I know my colleague has a phobia, I'll deal with the person and then like they can do the other side, you've got 17, 16 other patients, they look after the other 16"*

For this approach to work Lo8 stressed the importance of providing staff with a space where they could talk about how they feel about self harm, and tell people that they find it distressing. However, he acknowledged that this meant when staff working within the harm minimisation approach were not available, people were prevented from self harming:

> *Lo8: "So at times you find that somebody may have been stopped from self harming the previous shift and in the following shift they are allowed to do it. I know it creates inconsistencies and divides in team, but at the end of the day,*

we're not all the same. We're not all the same and we're not able to all able to cope with the same, at the same capacity, at the same, you know, so it's about give and take."

Harm minimisation meant providing a kit that could be used to clean service users' wounds, and on some occasions sharps for them to self harm with. It also meant teaching them how to clean their wounds and self harm safely:

Hi2: "We explained to her, and we gave her a kit. We said, "This is a swab. Whenever you cut yourself, ensure that you come to find this kit. You come and approach one of the nurses, who will give it to you." The kit hasn't got sharps; it was basically just swabs and sterilised - all the necessary equipment - material that she needed to clean herself properly. Then one of my colleagues and myself just taught her."

Hi2: *"We'd provide the same care plan, more or less; just revise it, but provided him with sharps"*

Lo9: "*Then we usually talk about how they can have safety if they really want to self harm and the areas they can do it. So we talked about where to cut and where not to cut"*

People were also asked to self harm in private, so it did not have an impact on other service users:

Hi2: "*Fellow patients do feel the stress as well. So we try our best as a team. I have spoken to the same patient, saying, "Please, keep it just in your room"*

If someone self harmed seriously then they were told to go to A&E, just as they would if they were at home:

Lo8: "*If it's too deep and they need to go to A&E, get the doctor to just assess and then like they go to A&E. But it ended up not even getting the doctor to assess. Turning up just saying like, 'OK, you've finished. OK, you're informal. Take yourself to A&E and do what you would do when you're at home"*

Hi6 explained that initially service users were not getting adequate treatment at A&E, and so the ward manager contacted the department to suggest a more suitable approach:

Hi6: "Cause one of the, one of our clients, was self harming and used to go to A&E and the nurses were sort of attending to her, sort of 'wow this girl is mad'

and take ages to attend to her, not before 5 hours, so she really felt it and our manager contacted their managers to say 'you know what, this patient isn't doing it deliberately it's just an illness, if she comes in just treat her like any other patient, not just ignore her for hours you know bleeding and all that stuff' I think that helped as well."

Hi2 felt that harm minimisation did not only reduce the risks associated with self harm, but also had a positive impact on people's emotional wellbeing, and helped to foster a supportive relationship between service users and staff. She felt that it was a way for staff to show that they understood and accepted the service user, and so it was important to communicate this when introducing the care plan:

Hi2: *"Hopefully, once you give that help, you actually convey to the patient, and give a proper rationale of why you're providing them with that, and encourage them to - not judging them, but telling them, "Yes, we understand it's something that you can't help. You're doing it, so we have accepted it. This is how you can do it well and ensure that you don't risk your health in terms of any infection, or any other risk."*

Another important consideration was service users' safety. Lo8 explained that he always would assess for suicidality, and when people were suicidal they would not be permitted to self harm:

Lo8: *"As long as they are safe and as long as they understand what they are doing, cause I think that's the biggest issue, the safety element… So if they're saying they're self harming to kill themselves, you've got a, you've got a problem. But if they say they're self harming to deal with a particular problem or cope with a particular problem, then it's a balancing, something you can work with. But if it to kill themselves, then you have to be, you have to go through the measures."*

6.6.4 Summary

Overall, staff had mixed views of harm minimisation. Those who had implemented the practice spoke very positively about it. They felt it reduced the incidence and severity of self harm and meant people were more likely to use safer methods. It also had a therapeutic effect, as it allowed staff to show they understood and accepted the service user. Many who had no experience of the approach were very anxious that self harm would increase in severity, possibly leading to a suicide. They were unsure how to assess whether a person was safe enough to have a harm minimisation care plan. Many staff disagreed with the approach because it challenged their core beliefs about the role

of the nurse, and the hospital, in supporting people who self harm. Many felt it was their responsibility to prevent people from harming themselves, and several also felt a moral responsibility to teach people that self harm is wrong. Others however felt harm minimisation could empower service users, and also provide an opportunity for them to reflect on the meaning of their behaviour. Those who had implemented the approach stressed the importance of allowing staff who object to it to be heard. Both wards had a lengthy process of consultation with staff before implementation, which also included contact with A&E.

6.7 Comparison of low and high antipathy staff

6.7.1 Understanding of self harm

As illustrated in Section 1, accounts of self harm were diverse and wide ranging. There were no systematic differences in the themes arising from interviews with high and low antipathy staff, however there were differences in the prevalence of certain beliefs about self harm between these groups of staff. The theme 'to get their own way' was more common amongst high antipathy staff (Table 38), and more of these staff constructed an understanding of self harm based on what they saw, or felt, when supporting people who self harm, or by adopting culture and practice (Table 38).

Table 38. Themes representing participant's understanding of self harm, by staff antipathy score

	Understanding of self harm			Ways of understanding		
	Relief from an unbearable state of mind	A cry for help	To get their own way	Active search for deeper meaning	Seeing and feeling	Adopting culture and practice
High antipathy	88%	63%	63%	63%	50%	75%
Low antipathy	90%	70%	20%	100%	30%	40%

There were no differences in the prevalence of themes, or the nature of accounts regarding the definitions of self harm and attempted suicide amongst high and low antipathy staff.

6.7.2 Staff views of harm minimisation practices

Again, there were no systematic differences in views of harm minimisation practices between high and low antipathy staff. However, more high antipathy staff were against harm minimisation practices compared to those with low antipathy scores (Table 39)

Table 39. Staff views of harm minimisation practices by antipathy score

	Pro harm minimisation	Against harm minimisation
Low antipathy	83%	17%
High antipathy	50%	50%

7. Discussion

This chapter presents an outline and discussion of key findings arising from this thesis, followed by a reflection on the methods used, and recommendations for practice, education and future research.

This thesis set out to address gaps in the literature identified following a systematic review of studies of inpatient self harm. Specifically, to describe the characteristics of self harm within a national sample of inpatient services and to investigate nursing staff's perceptions of self harm and harm minimisation practices. It composed of two studies; Study 1 was a documentary analysis of 500 incident reports of self harm collected from the National Patient Safety Agency. It aimed to investigate the characteristics of self harming behaviour within a national sample of psychiatric wards, and was the first national study of its kind. Study 2 was a sequential explanatory study that explored nursing attitudes and understanding of self harm, and was conducted in two stages; a survey of the attitudes of 395 nursing staff towards people who self harm, using the Self Harm Antipathy Scale (SHAS; Patterson et al., 2007a), followed by interviews with 18 participants, selected on the basis of their attitude scores. It was the largest survey of inpatient nursing staff attitudes towards self harm to date, and the first to examine how acts of 'self harm' and 'attempted suicide' are defined in practice. Study 2 tested the reliability of the SHAS, and also explored views of harm minimisation practices within inpatient psychiatry, which again, have not been studied before.

7.1 Summary of key findings

There was substantial variation in the amount of information provided in incident reports of self harm, which ranged from one line, to over 350 words in length. Self harm was mostly a very private act, which most often took place in bedrooms or bathrooms, and during the evening hours. In total, 141 different objects were used, most frequently doors, walls or windows for head banging or hitting, followed by clothing or underwear. Over twenty different methods of self harm featured in reports, which were grouped according to the characteristics of the behaviour. The most common methods involved breaking the skin, followed by restricting breathing, and outwardly aggressive methods such as head banging. The majority of episodes of self harm were low lethality, and most were by women. There were differences in the methods used by gender and type of ward; women were more likely to restrict their breathing, and men were more likely to use outwardly aggressive methods of self harm. People admitted to forensic services were

also more likely to self harm using outwardly aggressive methods, whilst those within acute services were more likely to self harm by self poisoning, or restricting their breathing. The most common antecedents to self harm were a distressing psychological state, conflict behaviours, and conflict with staff. Taking into account the numbers of beds within each service nationally, there were more episodes of self harm within forensic services.

Phase I of Study 2 measured staff attitudes of self harm using the SHAS, and also examined the psychometric properties of scale. Confirmatory factor analysis suggested a poor model fit, however this appeared to be mainly due to the 'Needs function' factor, as the exploratory factor analysis revealed a very similar structure to that proposed by Patterson et al. (2007a). These findings suggest that the factors proposed by the authors, minus 'needs function', is a relatively stable model of the latent constructs represented in the scale. The mean total SHAS score was towards the lower end of the possible range of scores, and there was large variation in scores within teams. Being a healthcare assistant, or from a non-white ethnic group were independently and significantly associated with higher antipathy scores, as were lower SF-36 scores for physical health and social functioning (indicating poorer physical and social functioning). There was a small, but significant, correlation between SHAS score and scores from the Attitudes to Patients Questionnaire (APQ). Effects for ethnicity and occupation were not replicated in APQ scores.

Staff accounts of the reasons for self harm, collected during Phase II of Study 2, were complex and wide ranging. Major themes were self harm which offered people relief from an unbearable state of mind, and self harm which was used to influence the behaviour of others. Participants described a variety of ways in which they felt self harm allowed service users to escape their emotional pain, however all believed these people were experiencing extreme levels of emotional distress, and saw self harm as providing an immediate respite from this. Self harm as 'a cry for help' was also described as a legitimate behaviour, used by people who were in need of support. Contrastingly, people described as self harming 'to get their own way' were not seen to be in need of help, and their behaviour was not accepted by staff. Participant's accounts of how they constructed their understanding of self harm were described in three themes; a search for a deeper meaning, seeing and feeling, or adopting culture and practice. Searching for a 'deeper meaning' of self harm meant entering into in depth conversations with service users about their experiences. Contrastingly, the theme 'seeing and feeling' captured descriptions of how staff based their understanding of self harm on what they observed or felt during practice. In these accounts, staff often interpreted self harm as being used to manipulate others. 'Adopting culture and practice' outlined how participants'

understanding of self harm was shaped by the knowledge and values which existed within the wards where they worked, or their culture as a whole.

All but one participant believed self harm and attempted suicide were distinct behaviours, which could be differentiated by inferring suicidality from the characteristics of the act of self harm, from what people told staff about their intent, and from the individual's state of mind. Acts which were high lethality, and which occurred during a time or place which meant it was unlikely that the person would be found, were generally classified as an attempted suicide. People who were suicidal were identified as being in more distress and secretive about what they felt. Paradoxically, this meant many staff believed that if a person told them they were suicidal, it meant they were less likely to be so. Some participants described self harm and attempted suicide as occurring in different 'types' of people, however others believed that suicidal feelings could fluctuate, such that self harm could escalate to an attempted suicide. Although many staff maintained they could clearly differentiate these two behaviours, there were contradictions in accounts which suggested this may not be the case. For example, descriptions of self harm and attempted suicide as being different levels of the same behaviour.

Two of the ten wards from which staff were interviewed had implemented harm minimisation practices. Overall, staff had mixed views of harm minimisation, but those who had implemented it spoke very positively about the approach. They felt it reduced the incidence and severity of self harm and meant that people were more likely to use safer methods. Staff believed harm minimisation also had a therapeutic effect, as it allowed them to show they understood and accepted service users' need to self harm. Many participants who had no experience of these practices were very anxious that self harm would increase in severity, possibly leading to a suicide. They were unsure how to assess whether a person was safe enough to have a harm minimisation care plan. Many staff disagreed with the approach because it challenged their core beliefs about the role of the nurse and the hospital (i.e. that they should protect people from harm). Staff who had implemented harm minimisation had been involved in a lengthy process of consultation with the nursing team before implementation, and stressed the importance of allowing staff who object to the approach to voice their concerns.

7.2 Discussion of key findings

This thesis confirms findings from smaller, single hospital studies, that inpatient self harm is more common on forensic vs acute wards, largely takes place in the private areas of the ward, during the evening hours, and constitutes a wide range of behaviours of which cutting is the most common (Beer et al., 2010; Mannion, 2009). Cutting is also consistently reported as the most common form of self harm within community, and

prison samples (Hawton et al., 2014; Klonsky et al., 2003; Moran et al., 2012), whilst self-poisoning is the most prevalent method amongst people presenting to accident and emergency departments (Hawton et al., 2007; Hawton et al., 1997). In this respect, inpatient self harm is comparable to that within the general population and other institutions. It is, however, difficult to draw conclusions regarding other methods of self harm because of differences in the ways in which these behaviours are defined between studies. For example, two of the largest UK population based studies did not consider outwardly aggressive methods of self harm, or methods of restricting breathing (Hawton et al., 2002; Meltzer et al., 2002). Furthermore, studies adopting a definition of 'any intentional harm to self regardless of intent' include data regarding self-poisonings (e.g. Hawton et al., 2002), whilst those using 'non suicidal self injury' do not (e.g. Klonsky, 2011).

The ongoing debate about whether or not it is valid to separate these behaviours into acts of 'self harm' and 'attempted suicide' is a significant barrier to the progress of research in this field (O'Carroll et al., 1996), and there is currently no agreed approach for the use of these terms in clinical practice. In the UK, the National Institute for Clinical Excellence (NICE) argues against the separation of these behaviours because "*motivation is complex and does not fall neatly into such categories*" (National institute for Health and Care Excellence, 2011, p. 14), whilst in the US, 'Non-Suicidal Self Injury' (NSSI) and 'Suicidal behaviour' are separate disorders, included in the DSM-5 (American Psychiatric Association, 2013). This study found that rather than using the definition outlined in UK guidance, nursing staff generally adopted the US approach where 'self harm' was used to refer to acts without suicidal intent, which were distinct from an 'attempted suicide'. Participants used a wide range of criteria to determine the presence, or absence, of suicidal intent. These differed between individuals, including those working on the same ward, indicating that there is no common understanding of the boundaries between self harm and attempted suicide amongst inpatient staff. The definition of these terms is therefore not just a problem for researchers, but also clinicians. This language communicates an assessment of the motivations for these behaviours, and more importantly, level of risk. This means the ways in which these terms are applied in practice will have an impact on how people are treated, particularly within inpatient services, where service users deemed to be high risk are subject to high levels of containment such as constant observation and restricted leave (Drew, 2001; Foster et al., 2007; Low et al., 1997). The significance of the language used to describe these acts was noted during Study 2, where a nurse outlined how the term 'attempted suicide' can provoke a strong reaction from staff, and have a lasting impact on how a person is treated in the future.

Lo7: "I think especially for the future, because if you document someone has made a suicide attempt in their risk assessment, you're branding them for the future. You're giving them a name, "She has tried to take her life". In the future, people become very scared. Services, I think, become very over protective and that's when there comes all this massive chaos around people"

A further problem is that the dichotomous separation of these behaviours may lead staff to overlook the strong association between self harm and suicide. For example, participants made a clear distinction between "self harmers" and "suicide patients", few acknowledged that those who self harm may also feel suicidal, and some described how people who both self harmed and expressed suicidal feelings were not taken seriously. This is a worrying finding, as a history of self harm is the strongest predictor of suicide, over and above all other psychosocial characteristics (Sakinofsky, 2000), such that between 40-60% of people who take their own life have previously self harmed (Hawton & Fagg, 1988; Rygnestad, 1988; Suokas & Lönnqvist, 1991).

These findings indicate that the language used to describe these behaviours, and consequent practice, particularly with respect to risk assessment, can be problematic for both practitioners and service users. Those in support of a separate diagnostic category of NSSI, however, argue that it will enable services to provide better support. They make the case that NSSI is distinct from suicidal behaviour (e.g. attempted suicide) because it occurs in the absence of suicidal intent, and so requires different approaches for prevention and treatment (Muehlenkamp, 2005). The inclusion of NSSI in the DSM-5 has led a number of studies to investigate the ways in which people using NSSI and those who have 'attempted suicide' are distinct. These studies have found some significant differences which have been presented as 'distinguishing characteristics', and therefore evidence that these behaviours are different (Muehlenkamp, Claes, Havertape, & Plener, 2012). For example, these data suggest that people who have attempted suicide have a more negative view of life (Muehlenkamp & Gutierrez, 2007; Whitlock & Knox, 2007), and are more likely to have experienced traumatic life events such as childhood abuse, the death of a friend of family member, and worries about their sexuality, compared to those who self harm (Baetens, Claes, Willem, Muehlenkamp, & Bijttebier, 2011; Whitlock & Knox, 2007). However, rather than being 'distinguishing' characteristics (i.e. which are present in one group and absent in another), these are characteristics that exist to a greater degree in one group compared to the other, suggesting a spectrum of behaviours rather than two distinct categories. This is a fundamental problem with the argument for NSSI as a separate category; intent is a fluid concept which is not either present or absent, but can exist to varying degrees, and fluctuate over time. For example, a study

of 106 people hospitalized following an attempted suicide found that fifty percent reported a co-occurring wish to live and to die at the time of the act, and service users experience self harm, suicidality and attempted suicide as part of a complex continuum (Ben-Zeev, Young, & Depp, 2012; National institute for Health and Care Excellence, 2011, p. 52). Consistent with these findings, a recent taxometric investigation of the latent structure of suicidal and non-suicidal self-injury amongst 1,525 female undergraduates concluded that these behaviours are dimensional variations of a single construct (Orlando, Broman-Fulks, Whitlock, Curtin, & Michael, 2015)

By highlighting the complexities involved in determining intent, the impact of the term 'attempted suicide' on perceptions of risk, and the consequent implications for practice, findings from this study add to a body of evidence which supports the definition adopted by NICE guidance. Staff should therefore be discouraged from using the term 'attempted suicide'. A more reliable way of communicating indicators of risk would be to report a detailed description of the circumstances and features of the act. One participant outlined how this would be a helpful approach:

> *Lo7: "I think sometimes they worded it that: "she attempted to strangle herself in an attempt to take her life." When really, I think it could have been worded differently: "She had just attended ward round and been told of her impending discharge. She was upset, and went back to her room and she was found with tights around her neck."*

This example could also include additional information such as a lethality rating or a description of lethality (e.g. an indication of how tight the ligature was, if it was tied, if it was attached to anything), the circumstances of the act (e.g. was the person likely to be found?), and an account of what the service user said about what they were experiencing at the time, including any suicidal ideation.

During interviews staff gave complex and wide ranging accounts of the reasons for self harm, which were in line with the diverse functions of the behaviour reported in survey studies (Briere & Gil, 1998; Klonsky, 2011; Paul, Tsypes, Eidlitz, Ernhout, & Whitlock, 2014; Saraff & Pepper, 2014), and qualitative studies of inpatient service users (Gardner & Gardner, 1975; Rosenthal et al., 1972). This study found that, on the whole, inpatient nursing staff had positive perceptions of people who self harm. These findings are supported by data from smaller survey studies, which also report relatively positive attitudes amongst this group (Gibb et al., 2010; Hauck et al., 2013; Kool et al., 2014; Wheatley & Austin-Payne, 2009). This is an important finding, as negative attitudes towards self harm amongst clinical staff are frequently highlighted in research reports (Brophy & Holmstrom, 2006; Royal College of Psychiatrists, 2010), clinical guidance

(National institute for Health and Care Excellence, 2011) and the research literature (McHale & Felton, 2010; Taylor et al., 2009). Most studies in this field have been conducted with general nurses in accident and emergency departments (Taylor et al., 2009), who have more negative attitudes compared to those working within mental health services (Commons-Treloar & Lewis, 2008; Patterson et al., 2007b). SHAS scores in this study were lower than those found in other settings (Conlon & O'Tuathail, 2012; Dickinson & Hurley, 2012; Dickinson et al., 2009; Patterson et al., 2007a), suggesting that because of their specialist training and experience in mental health, inpatient nurses are more accepting of self harm. Inpatient service users, however, frequently report negative experiences of care (Breeze & Repper, 1998; Duperouzel & Fish, 2010; Hume & Platt, 2007; Pembroke, 1994; Reece, 2005), and negative perceptions of self harm were also evident amongst staff in this study. Findings from this thesis indicate that on the whole inpatient staff have a good understanding of the reasons why people might self harm, and are accepting of the behaviour, but that there is a minority of staff who do have negative perceptions of self harm. Frequent reports of negative attitudes towards self harm amongst inpatient staff are likely to be reflective of this minority of staff, who have a significant impact on the experience of inpatient service users.

Although reflective of a minority of practitioners, the findings from this study replicate previous observations that some inpatient staff view people who self harm as 'manipulative' and 'attention seeking' (Sandy & Shaw, 2012; Smith, 2002; Wilstrand et al., 2007). This view was evident amongst participants with high antipathy scores, and those who described service users using these terms during interviews. Accounts of people who self harm as being 'manipulative' and 'attention seeking' are frequently cited as being illustrative of negative attitudes towards self harm amongst clinicians (McHale & Felton, 2010; National institute for Health and Care Excellence, 2011) however, are not entirely inaccurate as it is well established that self harm can be used to influence the behaviour of others (Nock & Prinstein, 2004). For example, survey studies have found people who self harm endorse reasons such as, "*to shock or hurt someone*", "*to seek attention*", *"to get other people to act differently or change*" or "*to control the reactions and behaviour of others*" (Brown, Comtois, & Linehan, 2002; Lindholm, Bjärehed, & Lundh, 2011; Scoliers et al., 2009; Shearer, 1994). The issue is not with these understandings of the behaviour per se, but the fact that participants who described people who self harm in these terms believed that, despite being in the care of acute mental health services, 'there was nothing wrong' with them- they were not in need of support, and were not suffering. A further issue is that a minority of staff appear to interpret most self harm in this way, as evidenced by high antipathy scores, particularly for the 'Client intent manipulation' sub scale. During interviews, staff rationalised these

accounts by explaining they could see no any 'evidence' that the person was in distress. These participants also gave descriptions of what they saw as more legitimate incidents of self harm, i.e. cases where it was clear the person was upset. These findings suggest that staff have an overall attitude towards self harm, but can view the behaviour differently in specific contexts. This is discussed further in section 7.3.

When giving an account of how they came to reach their understanding of self harm, staff rarely mentioned any psychological theory or indeed receiving any form of training, but when training or theory were mentioned, it was credited with having a positive effect. For example, a healthcare assistant who had attended a course described how it helped to change her perceptions of self harm (section 6.4.3), and one nurse used psychodynamic theory to explain why people self harmed during times when she was not available (section 6.4.1). This study also found that qualified nurses had more positive attitudes than unqualified healthcare assistants, regardless of how long they had worked in mental health, providing further evidence that training may help to improve attitudes. Training can enhance staff's 'psychological understanding' of a behaviour. That is, their ability to '*deploy a range of alternative explanations for the difficult behaviour of patients, derived from psychological models, studies or psychotherapeutic approaches, instead of judging patients to be morally bad'* (Bowers, 2014, p. 502). To date, just one study has evaluated the effectiveness of a training course on mental health nurses' attitudes towards self harm, and reported a 20% reduction in SHAS scores 18 months following the completion of a 15-week course (Patterson et al., 2007b). The gaps between theory and nursing practice, and the importance of continuing professional development, have been highlighted many times before in reports looking at ways to improve the care of people who self harm (Brophy & Holmstrom, 2006; National institute for Health and Care Excellence, 2011; Royal College of Psychiatrists, 2010) and also reports examining inpatient mental health nursing in general (Clarke, 2004; CSIP-NIMHE, 2008; Healthcare Commission, 2008). These findings suggest there are still significant barriers to the implementation of these recommendations in practice. A particular challenge within inpatient services is the lack of time and resources available to dedicate to the education of nursing staff, and difficulties in implementing new learning within the ward environment. One way in which wards may be able to sustain changes in practice is to change the ward routine, so that opportunities for learning form part of core ward activities (Clarke, 2004). For example, through the use of reflective staff groups (Heneghan, Wright, & Watson, 2013), reflective journals (Kuiper, 2001) or clinical supervision (Driscoll, 2007). A further barrier to developing staff's psychological understanding of self harm is the lack of research into the interpersonal forms of self harm which this study has found are associated with more negative perceptions amongst

staff. There is a paucity of research in this area (Bentley, Nock, & Barlow, 2014) as most studies and theoretical models focus mainly on the use of self harm to alleviate distress (Chapman, Gratz, & Brown, 2006). Researchers may be reluctant to explore these more social forms of self harm because they are associated with judgemental and negative attitudes, however the findings from this study indicate that staff would benefit from a greater understanding of these behaviours. Specifically, researchers should explore why some people who self harm may find interpersonal relationships difficult, or may struggle to communicate their needs or emotions in other more conventional ways.

Alternative understandings of self harm were not only generated from theory and training, but also during practice, in partnership with service users, through 'a search for a deeper meaning of self harm'. This meant entering into in depth conversations with people about their experiences, which enabled staff to empathise with service users and to understand their suffering. Contrastingly, staff who described making judgements about the meaning of self harm based on their own observations and feelings, or the views of other staff, without engaging in 'in depth' conversations with service users, were more likely to take a negative view of self harm. Inpatient nurses have often been criticised for not prioritising interaction with service users (Sharac et al., 2010), which is frequently attributed to a lack of time available due to ward processes such as handovers and ward rounds, large amounts of paperwork, risk management procedures and the short length of admissions (Healthcare Commission, 2008; Mathers, 2012). However, in addition to challenges related to the ward environment, clinicians report a lack of confidence in speaking to service users about their self harm (Dickinson et al., 2009; Friedman et al., 2006; McAllister et al., 2002), suggesting there are particular barriers to working with this group of people. This may be because these interactions require a particular level of skill, or knowledge, which clinicians feel they lack. An alternative explanation is that staff find the emotional content of these interactions difficult to manage. For example, they may fear triggering a further episode of self harm, or unable to manage the impact it might have on them. A detailed study of these 'in depth' conversations is required to identify what they involve, however, staff accounts illustrate elements of reflection and a person centred approach, seen to be key elements of nursing practice (Manley, Hills, & Marriot, 2011; UK Central Council for Nursing Midwifery and Health Visiting, 1999), and also point to therapeutic communication skills such as 'active listening' (Machin & Westrip, 2013) and critical thinking (Scriven, 1987). These skills are a core part of nursing training (UK Central Council for Nursing Midwifery and Health Visiting, 1999), suggesting that training not only provides staff with alternative theoretical understandings of self harm, but also the skills and confidence required to enter into 'in depth' conversations with service users, and, together discover the meaning

of their behaviour.

This study highlights the importance of specialist training in mental health for practitioners working with people who self harm. Untrained staff were significantly more likely to have negative attitudes towards self harm, and these findings indicate that training can both provide staff with 'psychological understandings' of the behaviour and also equip them with the skills required to enter into 'in depth' conversations with people about what self harm means to them. These skills and knowledge will play a particularly important role in helping staff to empathise with service users in cases where an individual may have difficulty communicating their distress, or understanding the reasons for their behaviour.

Inpatient nurses' perceptions of self harm were also strongly influenced by their cultural beliefs. This is an interesting finding, as cultural variations in perceptions of self harm have only been explored by one other study. Ramon and Breyter (1978) administered a case vignette measure to 79 doctors and nurses in Israel and the UK, and found that Israeli staff expressed less sympathy towards people who self harmed, and were more likely to perceive them as having problems and being manipulative. The authors did not collect data regarding the ethnic backgrounds of the staff, and so it cannot be assumed that all British staff were from a white British background. However, these findings do point to more positive perceptions of self harm within British culture. Further cross cultural research in this area is required, and should seek to understand the underlying reasons for these cultural differences, so that they can be considered during training and practice. A possible contributing factor, which should be explored in future studies, is the role of religion or religiosity, which has been implicated in a large body of work examining attitudes towards suicide. The religiosity theory states that suicidal behaviour is a violation of the moral code of conduct established by religion, and so people with religious beliefs will be less accepting of suicide (Boyd & Chung, 2012; Osafo, Knizek, Akotia, & Hjelmeland, 2013). The impact of religiosity on suicide acceptability is thought to act at both an individual level, and across society as a whole. The most robust evidence is from the World Values Survey; a global research project which has produced very large datasets representing people across almost 100 nations. Studies using these data have found that individual measures of religious orthodoxy, religious importance, and church attendance are strong and significant predictors of suicide acceptability, as are measures of religiosity at the country level such as church attendance and the proportions of religious people within a society (Boyd & Chung, 2012; Stack, 1998; Stack & Kposowa, 2008, 2011b). Studies have also found more positive attitudes towards suicide amongst secular vs religious populations within the same country (Agnew, 1998; Sun, Long, & Boore, 2007). Whilst most religions clearly state

that suicide as a sin (Boyd & Chung, 2012), teachings regarding self harm are less clear. However, it is possible that religious arguments for the immorality of suicide could also impact perceptions of self harm. For example, both Christianity and Islam teach that the body is a gift from God, and so should not be intentionally damaged. Although data regarding religion was not collected in this study, religion is more prominent among minority populations in the UK (*Office for National Statistics, 2011 Census: Aggregate data (England and Wales*, 2011), and this would explain why the relationship between culture and attitudes was specific to self harm, and not to service users as a whole.

Another influential sociological theory, which could be applied to these findings, is the axis of survivalist vs self-expressive values existing within a culture. This theory states that people within cultures where there is a struggle for survival adopt values which support a more cohesive, secure society, whilst those who live within more developed countries value self-expression, and so are more tolerant of individual differences (Inglehart & Baker, 2000). This theory is not so easily applied to the sample in this study, where people identifying as 'African', for example, may have been born in a survivalist culture but are now residing in a more developed country, or may have 'migrant origins' but have never lived in Africa themselves. Individual levels of self expressionism have been found to be predictive of attitudes towards suicide, however the level of self expressionism within a society is not (Boyd & Chung, 2012; Stack & Kposowa, 2011a), lending less support to this hypothesis. In addition, if survivalist values are driving positive perceptions towards self harm, one may also expect people to be less accepting of those with mental illness, which in this sample, was not the case. Nevertheless, given their influence in the study of cultural differences these variables are worth consideration in further research.

The findings from this thesis suggest that amongst culturally diverse teams of staff there will be multiple understandings of self harm, and those from high religiosity ethnic backgrounds in particular, may be less accepting. This is likely to have an impact on the continuity of care, and will present a particular challenge to those training, and managing teams of staff in multi-cultural areas within the UK such as London, Manchester and Birmingham (Sunak, 2014). Staff rarely mentioned theory or training during their interviews, and so it may be that this lack of theoretical knowledge means staff are more likely to draw on their cultural understandings. If so, training in self harm may help to address these issues. Studies evaluating the impact of training should therefore examine its effects by ethnicity, or religion. It may be necessary for training to specifically address the key cultural or religious beliefs that influence attitude towards self harm, so that staff can be supported to reconcile these religious beliefs with their professional responsibilities. Future research should seek to identify what these key

beliefs are, which could then form an important part of cultural competence training for ward managers. Another implication of this finding is that people from minority ethnic or religious groups who self harm may particularly struggle with feelings of stigma.

The findings from this study indicate that the SHAS is a reliable measure of inpatient staff attitudes towards self harm, and so support its use in future research. The scale detected significant differences in attitude by ethnicity and occupation and demonstrated a relatively stable structure across populations. However, data indicate that attitudes towards self harm may be influenced by a number of factors which are not represented in the scale, and so future studies may wish to include some additional measures such as the amount of specialist training in self harm, or a measure of religiosity. This could include a separate scale of statements about religion and self harm, for example: self harm is a sin/most people who self harm are not religious/people who self harm lack faith in god. Qualitative data also revealed that staff had different attitudes depending on the context of the act; some were accepting of self harm when they felt it was being used to relieve an unbearable state of mind, yet did not accept self harm where there was no 'evidence' of distress. Researchers interested in capturing these differences could use a vignette measure which includes descriptions of an episode of self harm where someone is clearly in distress, and an incident where there is no visible distress, with corresponding measures of staff attitudes towards the people depicted in these cases.

An unexpected finding from this study was that two of the ten wards from which staff were interviewed were implementing harm minimisation practices. All those who had used this approach felt it reduced the incidence of self harm, and so this data adds to a growing body of research which suggests there may be benefits of using these practices with some people who self harm. This includes reports from inpatient service users that being prevented from self harming causes them more distress, and can lead to an escalation in their self harming behaviour (Duperouzel & Fish, 2008; Lindgren et al., 2011; Pembroke, 1994). To date, there have been no rigorous studies of the impact of these practices on rates of self harm, or the mental wellbeing of service users. Studies examining rates before, and after, implementation of a harm minimisation programme have reported a reduction in incidents, however were conducted within single services, with small samples, and no controls (Birch et al., 2011; Holley, Horton, Cartmail, & Bradley, 2012). This study identified several challenges faced by wards who wish to implement this approach, not least issues around the management of risk. As previously discussed, there is a strong association between self harm and suicide, and staff were unsure how to assess whether a person was safe enough to have a harm minimisation care plan. These decisions, and the ongoing assessment of risk under a harm

minimisation approach, are complex issues, which are likely to be dependent on a wide range of factors. Yet very little is known about how they are, or should be, made in practice. Another significant challenge is reaching an agreement regarding this approach amongst teams of staff. This study found mixed views of harm minimisation amongst inpatient staff, however most did not believe people should be allowed to self harm in a safe environment. There are likely to be very strong and opposing beliefs within teams about the morality of self harm and, for some, it challenges fundamental beliefs regarding what it means to be a nurse. One ward was not able to reach agreement, which meant that when some staff were on shift people were stopped from self harming, whilst when others were working they were not. This is not an ideal approach, however forcing staff to tolerate self harm is also likely to have a negative impact on their wellbeing. One ward found that staff who were initially against harm minimisation changed their minds once it was implemented and they saw it reduced self harm. Again, more research is required to determine the best way to manage these issues in practice. An important finding from this study is that harm minimisation requires nurses to completely revaluate their role; to relinquish control, and allow people to take responsibility for their own behaviour. Through this process, staff were able to accept self harm, which also had a powerful impact on service users because it meant they felt understood and accepted, and this played an important role in their recovery. Inpatient psychiatry is often criticised for being too controlling and risk averse (Braithwaite, 2006; Brennan et al., 2006; Royal College of Psychiatrists, 2011), and it may be possible that because harm minimisation requires nurses to completely reconceptualise their role, its implementation could lead to less restrictive practices across inpatient nursing as a whole.

7.3 Reflection on methods used

For Study 1, a cross sectional documentary analysis was chosen because a national study of self harm using any other design would involve a very lengthy process of recruitment and data collection not possible within the time constraints of the study. The main limitation of this design is the possible source of bias in the data; incident reports do not include the service user's account of the event, and staff may feel under pressure to present a favourable account of their practice. However, because these reports are an official record and are completed soon after an episode of self harm they are, at least, likely to be an accurate description of objective characteristics of self harm such as the method used, the location and timing, etc. Descriptions of the antecedents to the incident, or the nursing response following the event are more likely to be subject to bias, but because much of this information was missing from reports it was not possible to draw any firm conclusions from these data. This was an exploratory study, and so a

sample size calculation was not performed. A sample of 500 reports were selected as this was considered to be manageable number to analyse, given the time constraints of the study, and were randomly selected to mitigate sample bias. The characteristics of self harm were very similar to those reported from single hospital studies, and within community samples (Beer et al., 2010; Klonsky, 2011; Mannion, 2009; Moran et al., 2012) and the study also replicated findings regarding a link between methods and gender reported elsewhere (Bowers et al., 2011), suggesting that this sample may be reflective of wider patterns of self harm within inpatient services.

Study 2 was one of the largest studies of attitudes towards self harm to date, and the largest conducted within inpatient services. It formed part of a Randomised Controlled Trial, and so followed a rigorous sampling strategy, in which wards were randomly selected from a list of all NHS hospitals in the South East of England. Multivariate statistical tests were employed to examine relationships between SHAS scores and staff characteristics. Only variables found to be significant at the 0.01 level were entered into the linear regression model, and post hoc analyses revealed no mullticollinearty or interaction effects. Six hundred and thirty staff met the criteria for inclusion in the study, 544 (86.3%) consented to participate, of which 395 completed questionnaires, giving a response rate of 62.6%. This response rate is comparable to, if not slightly higher than similar studies in inpatient services (Dickinson & Hurley, 2012; Dickinson et al., 2009; Wheatley & Austin-Payne, 2009), and is within the range of acceptable response rates for survey studies (American Association for Public Opinion Research, 2015; Kiess & Bloomquist, 1985). The majority of the wards participating in this study were based in London, which has a more ethnically diverse staff demographic compared to services within the whole of England (Bowers, 2009), and so given the association between attitude and ethnicity, the mean SHAS score for this sample is not likely to reflect staff attitudes towards self harm across the UK as a whole.

Attitudes towards self harm were measured using the Self Harm Antipathy Scale (Patterson et al., 2007a). There has been some criticism of the use of self report Likert scales, such as the SHAS, to measure attitudes, because they are subject to various forms of response bias, and social desirability bias. Research using both implicit, and explicit (e.g. Likert) self report measures of attitude towards self harm has found that self report measures are equally as reliable as more objective implicit measures of attitude (Knowles & Townsend, 2012). Steps were taken during data collection to protect anonymity and so minimise social desirability bias. For example, questionnaires were labelled with an ID number and returned in a sealed envelope via a deposit box. The SHAS formed part of a pack of questionnaires, and so participants were unaware that the study had a particular focus on self harm. During this study, a number of statistical

procedures were applied to assess the structure of the SHAS, which demonstrated good convergent and discriminant validity, a relatively stable structure across populations and detected significant differences in attitude by ethnicity and occupation which can be supported by previous findings regarding staff attitudes towards self harm, and suicide. During the qualitative phase of the study, high antipathy participants were far more difficult to recruit than those with low antipathy scores, suggesting that these groups of staff do behave differently, and so providing further evidence for the validity of the scale. In addition, during interviews high antipathy staff expressed more negative views of self harm (e.g. that there is 'nothing wrong' with people who self harm), compared to low antipathy staff, and were, on the whole, against harm minimisation practices (Table 39). Correspondingly, disagreement with statements regarding people's right to self harm indicated a more negative attitude on the SHAS.

A sequential explanatory design was selected for Study 2, which aimed to identify the attitudes of self harm amongst inpatient staff, and to explore how staff construct their understanding of self harm. This type of study uses qualitative data to elaborate, or expand on the findings of a quantitative study, and so fit well with the research aims. The findings from this study illustrate the benefits of using this approach as the quantitative data displayed how attitudes were related to other variables, such as ethnicity, whilst the qualitative data provided a more nuanced account, which helped to explain these findings, and revealed how attitudes can vary in different contexts. These complexities would not have been captured by a scale alone. A possible limitation of this design is that because it uses mixed methods, there can be inconsistencies between qualitative and quantitative data. As discussed above, there were some qualitative differences between high and low antipathy staff, however some participants with low antipathy scores did express negative perceptions of self harm (Table 38), whilst others with high antipathy scores did appear to be accepting of self harm in some contexts (i.e. obvious emotional distress). Discrepancies in qualitative and quantitative data regarding staff attitudes was also noted during the literature review (section 1.12). This could be due to a limitation of these data (i.e. it is not a true reflection of staff attitude towards self harm). This, however, is unlikely as care was taken to present an accurate description of staff accounts during interviews (see below for a discussion of the credibility of interview data), and, as outlined above, the findings from this study suggest the SHAS is a reliable measure of staff attitude. An alternative explanation is that, while staff have an overall attitude towards self harm, this can sometimes vary in different contexts, which would explain why participants' views of self harm in particular cases (mentioned during interviews) may not be in line with their overall attitude as measured by the SHAS.

Ensuring the credibility of qualitative data is considered to be one of the most

important factors in demonstrating its trustworthiness (Guba, 1987). To this end, participants were randomly selected from a random selection of wards in the East of England. The analysis was regularly reviewed during supervision, and a reflective commentary provided (Shenton, 2004; Appendix F). A mixed methods design was adopted to provide a comprehensive understanding of staff perceptions of self harm (Seale et al., 2004) and the findings from the thematic analysis supported the survey findings. For example, culture was a key theme contributing to staff understanding of self harm, and correspondingly, ethnicity was significantly and independently related to attitude score. This triangulation of data provides further support for the validity of the qualitative analysis.

7.4 Recommendations

The following section outlines recommendations for practice, nursing education, and future research, arising from this thesis

7.4.1 Recommendations for future research

1. An in depth study of the relationship between ethnicity and attitude toward self harm

A mixed methods study conducted in a multi-ethnic area of the UK such as London, Birmingham or Leeds which aims to identify causal factors for the effect of ethnicity on attitude towards self harm, would help to develop a theory regarding the relationship between attitude towards self harm and ethnicity. This could examine differences in SHAS score between religious and non-religious people, and could also look at the relationship between attitudes and measures of religiosity such as church attendance, orthodoxy and religious importance. It could also include measures of survivalist/self expressionist values, and should collect data regarding country of birth, and length of time living in the UK. Any factors found to be associated with attitude towards self harm could then be explored further in qualitative interviews with the study participants.

2. A realistic evaluation of harm minimisation practices within inpatient services

This study should seek to understand the impact of harm minimisation on service users and staff, and if suitable, develop a programme theory which outlines how outcomes are achieved. The study should examine how harm minimisation is implemented on wards, with a particular focus on the management of risk, and could explore the wider implications of this approach for nursing practice. Methods could include a documentary

analysis of care plans and clinical reports, interviews with service users and staff, observations of team discussions and interactions with service users, and, if possible, a time series analysis of the incidence of self harm pre and post implementation of harm minimisation.

3. A study of interactions between inpatient nursing staff and service users who self harm

This study would examine the content of conversations between nursing staff and people who self harm, and aim to describe how these interactions are used to construct an understanding of the meaning of self harm. Conversations could be audiotaped, and subject to conversation analysis. The findings of this study could be used to develop some form of guidance or training, to help staff build the necessary skills and confidence so they are better able to enter into these conversations with service users.

4. A focus on the interpersonal forms of self harm

Future research should focus on the interpersonal functions of self harm. Bentley et al. (2014) have made a number of recommendations for future studies, including an investigation of specific interpersonal skills amongst people who self harm, such as facial emotion recognition and facial mimicry. It would also be important to explore the reasons why people who self harm may find interpersonal relationships difficult. For example, due to abuse or neglect during childhood, or in adult relationships, and particularly the reasons why some people who self harm may find it difficult to communicate their feelings. This would help to equip staff with alternative 'psychological understandings' of self harming behaviour.

7.4.2 Recommendations for education of nursing staff

1. Training on self harm should focus on the relationship between self harm and suicide

Staff underestimated the link between suicide and self harm, often describing these as behaviours that did not occur within the same person. Training should focus on the link between self harm and suicide, and include explanatory models for the relationship between these behaviours (e.g. Joiner, 2005), service user accounts of their experiences of self harm and suicidal ideation and the implications for risk assessment (e.g., risk assessment should be a continuous process).

2. Training on self harm should focus on the interpersonal functions of self harm

The interpersonal functions of self harm are complex, often neglected, and have the biggest impact on nursing staff. There is a need for more research in this area, however training should focus on current theory regarding the social nature of self harm, so that staff can draw on these understandings. For example, some studies have found that people who self harm show deficits in social problem solving skills (Nock & Mendes, 2008), report more difficulty in social interactions, and less social support than their peers (Claes et al., 2010; Muehlenkamp et al., 2013), are less likely to seek help from others, and more likely to use avoidant coping strategies (Evans, Hawton, & Rodham, 2005). One theory suggests that self harm provides a way for people who have difficulty in social situations to communicate with others, and is effective because it elicits a strong response, which also reinforces the behaviour (Bentley et al., 2014; Nock, 2008; Nock & Prinstein, 2004).

3. Specialist training for healthcare assistants

Healthcare assistants had more negative perceptions of those who self harm compared to nurses, suggesting that training may help to improve attitudes. Training should offer alternative psychological understandings for self harm, and also equip staff with the skills to enter into in depth conversations with people about what self harm means to them. This could form part of the ward induction process. If training off the ward is not possible, then HCAs could be asked to observe conversations between qualified staff and service users about self harm. They could also be given a list of papers or booklets on self harm to read, and then discuss during supervision. This should include information about the functions of self harm, strategies for speaking with people about the reasons for self harm, and also aim to develop critical and reflective thinking skills.

4. Examine effects of training by ethnicity

When monitoring the impact of training courses, staff should look at effects by ethnicity. If training has a lower impact amongst certain ethic groups, then the course may need to explore ways in which staff can reconcile their belief systems with their duties as a nurse.

7.4.3 Recommendations for practice

1. Stop using the term ‘attempted suicide’ in nursing textbooks and clinical documents

The current definition of ‘self harm’ in the UK does not discriminate between self harm and attempted suicide (National institute for Health and Care Excellence, 2011), however

findings from this study suggest that these terms are used in practice, and that the term ‘attempted suicide’ is problematic. ‘Attempted suicide’ should therefore not be used in nursing textbooks and clinical documents including policy documents, clinical notes and incident reports. Instead the term ‘self harm’ should be defined as outlined in NICE clinical guidance, and when giving an account of an act of self harm, staff should provide a detailed description of the features of the act, as discussed in section 7.2

2. Ward managers should ensure opportunities for reflective practice form part of routine ward activities

The findings from this study suggest that generating new understandings of self harm help staff to avoid making reflexive judgements of the behaviour. One way in which this could be achieved during practice is through employing critical and reflective thinking. The development of these skills already forms an important part of undergraduate nursing education (UK Central Council for Nursing Midwifery and Health Visiting, 1999), however may be neglected in practice. A culture of reflective practice could be generated on wards by ward managers through the use of reflective staff groups (Heneghan et al., 2013), reflective journals (Kuiper, 2001) or regular clinical supervision (Driscoll, 2007)

8. References

Abidin, Z., Davoren, M., Naughton, L., Gibbons, O., Nulty, A., & Kennedy, H. G. (2013). Susceptibility (risk and protective) factors for in-patient violence and self-harm: prospective study of structured professional judgement instruments START and SAPROF, DUNDRUM-3 and DUNDRUM-4 in forensic mental health services. *BMC psychiatry, 13*(1), 197.

Agnew, R. (1998). The approval of suicide: A social-psychological model. *Suicide and Life-Threatening Behavior, 28*(2), 205-225.

American Association for Public Opinion Research. (2015). Standard Definitions: Final Dispositions of Case Codes and Outcome Rates for Surveys. MI.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders, (DSM-5)*: American Psychiatric Association.

Anderson, M., Standen, P., & Noon, J. (2003). Nurses' and doctors' perceptions of young people who engage in suicidal behaviour: a contemporary grounded theory analysis. *International Journal of Nursing Studies, 40*(6), 587-597.

Andover, M. S., Pepper, C. M., Ryabchenko, K. A., Orrico, E. G., & Gibb, B. E. (2005). Self-Mutilation and Symptoms of Depression, Anxiety, and Borderline Personality Disorder. *Suicide and Life-Threatening Behavior, 35*(5), 581-591.

Babiker, G., & Arnold, L. (1997). *The language of injury: Comprehending self-mutilation*: Blackwell Publishing.

Baetens, I., Claes, L., Willem, L., Muehlenkamp, J., & Bijttebier, P. (2011). The relationship between non-suicidal self-injury and temperament in male and female adolescents based on child-and parent-report. *Personality and Individual Differences, 50*(4), 527-530.

Baker, C. D. (2001). Ethnomethodological analyses of interviews *Handbook of Interview Research* (pp. 777-796). Thousand Oaks, CA: SAGE Publications.

Beasley, S. (1999). Deliberate self harm in medium security. *Nursing Management, 6*(8), 29-33.

Beer, D. M., Muthukumaraswamy, A., Khan, A. A., & Musabbir, M. A. (2010). Clinical characteristics of patients with self harming behaviour in a low secure mental health unit. *Journal of Psychiatric Intensive Care, 6*, 15-21.

Bellus, S. B., Vergo, J. G., Kost, P. P., Stewart, D., & Barkstrom, S. R. (1999). Behavioral Rehabilitation and the reduction of aggressive and self-injurious behaviors with cognitively impaired, chronic psychiatric inpatients. *Psychiatric Quarterly, 70*(1), 27-37.

Ben-Zeev, D., Young, M. A., & Depp, C. A. (2012). Real-time predictors of suicidal ideation: mobile assessment of hospitalized depressed patients. *Psychiatry research, 197*(1), 55-59.

Bentley, K. H., Nock, M. K., & Barlow, D. H. (2014). The Four-Function Model of Nonsuicidal Self-Injury Key Directions for Future Research. *Clinical Psychological Science, 2*(5), 638-656.

Berelson, B. (1952). *Content analysis in communication research*. Glencoe, Illinois: Free Press, 1952.

Bergen, H., Hawton, K., Waters, K., Cooper, J., & Kapur, N. (2010). Epidemiology and trends in non-fatal self-harm in three centres in England: 2000–2007. *The British Journal of Psychiatry, 197*(6), 493-498.

Bergen, H., Hawton, K., Waters, K., Ness, J., Cooper, J., Steeg, S., & Kapur, N. (2012). Premature death after self-harm: a multicentre cohort study. *The Lancet, 380*(9853), 1568-1574.

Birch, S., Cole, S., Hunt, K., Edwards, B., & Reaney, E. (2011). Self-harm and the positive risk taking approach. Can being able to think about the possibility of harm reduce the frequency of actual harm? *Journal of Mental Health, 20*(3), 293-303.

Bisconer, S. W., Green, M., Mallon-Czajka, J., & Johnson, J. S. (2006). Managing aggression in a psychiatric hospital using a behaviour plan: a case study. *Journal of psychiatric and mental health nursing, 13*, 515-521.

Booth-Kewley, S., Edwards, J. E., & Rosenfeld, P. (1992). Impression management, social desirability, and computer administration of attitude questionnaires: Does the computer make a difference? *Journal of Applied Psychology, 77*(4), 562.

Booth, R., Keogh, K., Doyle, J., & Owens, T. (2014). Living through distress: a skills training group for reducing deliberate self-harm. *Behavioural and cognitive psychotherapy, 42*(02), 156-165.

Borrell, C., Morrison, J., Burstrom, B., Pons-Vigués, M., Hoffmann, R., Gandarillas, A., . . . Díez, È. (2012). Comparison of health policy documents of European cities: Are they oriented to reduce inequalities in health&quest. *Journal of public health policy, 34*(1), 100-120.

Bowers, L. (2005). Reasons for admission and their implications for the nature of acute inpatient psychiatric nursing. *Journal of psychiatric and mental health nursing, 12*(2), 231-236.

Bowers, L. (2009). Association between staff factors and levels of conflict and containment on acute psychiatric wards in England. *Psychiatric Services, 60*(2), 231-239.

Bowers, L. (2014). Safewards: a new model of conflict and containment on psychiatric wards. *Journal of psychiatric and mental health nursing, 21*(6), 499-508.

Bowers, L., Alexander, J., Callaghan, P., Eales, S., Guy, S., McCann, E., & Ryan, C. (2002). Safety and security policies on psychiatric acute admission wards: results from a London-wide survey. *Journal of psychiatric and mental health nursing, 9*, 427-433.

Bowers, L., & Allan, T. (2006). The Attitude to Personality Disorder Questionnaire: psychometric properties and results. *Journal of personality disorders, 20*(3), 281-293.

Bowers, L., Allan, T., Simpson, A., Nijman, H., & Warren, J. (2007). Adverse incidents, patient flow and nursing workforce variables on acute psychiatric wards: The Tompkins Acute Ward Study. *International journal of social psychiatry, 53*(1), 75-84.

Bowers, L., Carr-Walker, P., Allan, T., Callaghan, P., Nijman, H., & Paton, J. (2006). Attitude to personality disorder among prison officers working in a dangerous and severe personality disorder unit. *International Journal of Law and Psychiatry, 29*(5), 333-342.

Bowers, L., Dack, C., Gul, N., Thomas, B., & James, K. (2011). Learning from prevented suicide in psychiatric inpatient care: an analysis of data from the National Patient Safety Agency. *International Journal of Nursing Studies, 48*(12), 1459-1465.

Bowers, L., Douzenis, A., Galeazzi, G., Forghieri, M., Tsopelas, C., Simpson, A., & Allan, T. (2005). Disruptive and dangerous behaviour by patients on acute psychiatric wards in three European centres. . *Social psychiatry and psychiatric epidemiology, 40*, 822-828.

Bowers, L., Flood, C., Brennan, G., & Allan, T. (2008). A replication study of the city nurses intervention: reducing conflict and containment on three acute psychiatric wards. *Journal of psychiatric and mental health nursing, 15*, 737-742.

Bowers, L., Flood, C., Brennan, G., LiPang, M., & Oladapo, P. (2006). Preliminary outcomes of a trial to reduce conflict and containment on acute psychiatric wards: City Nurses. *Journal of psychiatric and mental health nursing, 13*, 165-172.

Bowers, L., Simpson, A., & Alexander, J. (2003). Patient-staff conflict: Results of a survey on acute psychiatric wards. *Social Psychiatry & Psychiatric Epidemiology., 38*(7), 402-408.

Bowers, L., Whittington, R., Nolan, P., Parkin, D., Curtis, S., Bhui, K., . . . Simpson, A. (2008). The relationship between service ecology, special observation and self-harm during acute in-patient care: the City-128 study. *British Journal of Psychiatry, 193*(5), 395-401.

Boyd, K. A., & Chung, H. (2012). Opinions toward suicide: Cross-national evaluation of cultural and religious effects on individuals. *Social science research, 41*(6), 1565-1580.

Braithwaite, T. (2006). The Search for Acute Solutions. *Improving the Quality of Care in Acute Psychiatric Wards. London: Sainsbury Centre for Mental Health*.

Brannen, J., Dodd, K., Oakley, A., & Storey, P. (1994). *Young people, health, and family life*. Buckingham: Open University Press

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology, 3*(2), 77-101.

Breeze, J. A., & Repper, J. (1998). Struggling for control: the care experiences of 'difficult' patients in mental health services. *Journal of advanced nursing, 28* (6), 1301-1311.

Brennan, G., Flood, C., & Bowers, L. (2006). Constraints and blocks to change and improvement on acute psychiatric wards–lessons from the City Nurses project. *Journal of psychiatric and mental health nursing, 13*(5), 475-482.

Briere, J., & Gil, E. (1998). Self-mutilation in clinical and general population samples: prevalence, correlates, and functions. *American Journal of Orthopsychiatry, 68*(4), 609.

Brophy, M., & Holmstrom, R. (2006). *Truth Hurts: Report of the National Inquiry Into Self-harm Among Young People: Fact Or Fiction?* : Mental Health Foundation.

Brown, M. Z., Comtois, K. A., & Linehan, M. M. (2002). Reasons for suicide attempts and nonsuicidal self-injury in women with borderline personality disorder. *Journal of abnormal psychology, 111*(1), 198.

Brown, S., & Bass, N. (2004). The psychiatric intensive care unit: patient characteristics, treatment and outcome. *Journal of Mental Health, 13*(6), 601-609.

Bryman, A. (2012). *Social research methods*: Oxford university press.

Burrow, S. (1992). The deliberate self-harming behaviour of patients within a British special hospital. *Journal of advanced nursing, 17*(2), 138-148.

Callias, C. G., & Carpenter, M. D. (1994). Self-injurious behavior in a state psychiatric hospital. *Hospital & Community Psychiatry, 45*(2), 170-172.

Carlen, P., & Bengtsson, A. (2007). Suicidal patients as experienced by psychiatric nurses in inpatient care. *International Journal of Mental Health Nursing, 16*, 257-265.

Cassidy, C., Smith, A., & Arnot-Smith, J. (2011). Critical incident reports concerning anaesthetic equipment: analysis of the UK National Reporting and Learning System (NRLS) data from 2006–2008. *Anaesthesia, 66*(10), 879-888.

Chapman, A. L., Gratz, K. L., & Brown, M. Z. (2006). Solving the puzzle of deliberate self-harm: The experiential avoidance model. *Behaviour research and therapy, 44*(3), 371-394.

Claes, L., Klonsky, E. D., Muehlenkamp, J., Kuppens, P., & Vandereycken, W. (2010). The affect-regulation function of nonsuicidal self-injury in eating-disordered patients: which affect states are regulated? *Comprehensive psychiatry, 51*(4), 386-392.

Clarke, S. (2004). *Acute Inpatient Mental Health Care: Education, Training & Continuing Professional Development for All*: Department of Health.

Commons-Treloar, A. J., & Lewis, A. J. (2008). Professional attitudes towards deliberate self-harm in patients with borderline personality disorder. *Australasian Psychiatry, 42*(7), 578-584.

Conlon, M., & O'Tuathail, C. (2012). Measuring emergency department nurses' attitudes towards deliberate self-harm using the Self-Harm Antipathy Scale. *International emergency nursing, 20*(1), 3-13.

Coons, P. M., & Milstein, V. (1990). Self-mutilation associated with dissociative disorders. *Dissociation: Progress in the Dissociative Disorders*.

Cooper, J., Kapur, N., Webb, R., Lawlor, M., Guthrie, E., Mackway-Jones, K., & Appleby, L. (2005). Suicide after deliberate self-harm: a 4-year cohort study. *Suicide, 162*(2).

Cooper, J., Steeg, S., Gunnell, D., Webb, R., Hawton, K., Bennewith, O., . . . Kapur, N. (2015). Variations in the hospital management of self-harm and patient outcome: A multi-site observational study in England. *Journal of Affective Disorders, 174*, 101-105.

Crawford, T., Geraghty, W., Street, K., & Simonoff, E. (2003). Staff knowledge and attitudes towards deliberate self-harm in adolescents. *Journal of Adolescence, 26*(5), 619-629.

Creswell, J. W., Plano Clark, V. L., Gutmann, M. L., & Hanson, W. E. (2003). Advanced mixed methods research designs. In A. Tashakkori & C. Teddlie (Eds.), *Handbook of mixed methods in social and behavioral research* (pp. 209-240). London: SAGE Publications.

CSIP- NIMHE. (2008). More than just staffing numbers: A workbook for acute care workforce redesign and development.

Daffern, M., & Howells, K. (2007). The prediction of imminent aggression and self-harm in personality disordered patients of a high security hospital using the HCR-20 clinical scale and the dynamic appraisal of situational aggression. *6*, 137-143.

Davis, B. D., Billings, J. R., & Ryland, R. K. (1994). Evaluation of nursing process documentation. *Journal of advanced nursing, 19*(5), 960-968.

De Houwer, J., Teige-Mocigemba, S., Spruyt, A., & Moors, A. (2009). Implicit measures: A normative analysis and review. *Psychological bulletin, 135*(3), 347.

De Leo, D. B., S., Bertolote, JM, Kerkhof, AJFM, & Bille-Brahe, U. (2006). Definitions of suicidal behavior: Lessons learned from the WHO/EURO Multicentre Study. *Crisis, 27*(1), 4-15.

Department of Health. (2000). Working Partnerships. Consumers in Research Working Partnerships. Consumers in Research. Third Annual Report. London.

Department of Health. (2002). National Suicide Prevention Strategy for England. London, UK.

Department of Health. (2005). Research governance framework for health and social care: Department of Health.

Dickinson, T., & Hurley, M. (2012). Exploring the antipathy of nursing staff who work within secure healthcare facilities across the United Kingdom to young people who self-harm. *Journal of advanced nursing, 68*(1), 147-158.

Dickinson, T., Wright, K., & Harrison, J. (2009). The attitudes of nursing staff in secure environments to young people who self-harm. *Journal of psychiatric and mental health nursing, 16*(10), 947-951.

Drew, B. (2001). Self-harm behaviour and no-suicide contracting in psychiatric inpatient settings. *Archives of psychiatric nursing, 15*, 99-106.

Driscoll, J. (2007). *Practising Clinical Supervision: a reflective approach for healthcare professionals*: Elsevier Health Sciences.

Duperouzel, H., & Fish, R. (2008). Why couldn't I stop her? Self injury: the views of staff and clients in a medium secure unit. *British Journal of Learning Disabilities, 36*(1), 59-65.

Duperouzel, H., & Fish, R. (2010). Hurting No-One Else's Body but Your Own: People with Intellectual Disability Who Self Injure in a Forensic Service. *Journal of Applied Research in Intellectual Disabilities, 23*(6), 606-615.

Ehmann, T. S., Smith, G. N., Yamamoto, A., McCarthy, N., Ross, D., Au, T., . . . Honer, W. G. (2001). Violence in treatment resistance psychotic inpatients. *The Journal of nervous and mental disease, 189*(10), 716-721.

Ennis, L., & Wykes, T. (2013). Impact of patient involvement in mental health research. *British Journal of Psychiatry*, 381-386. doi: doi: 10.1192/bjp.bp.112.119818

Evans, E., Hawton, K., & Rodham, K. (2005). In what ways are adolescents who engage in self-harm or experience thoughts of self-harm different in terms of help-

seeking, communication and coping strategies? *Journal of Adolescence, 28*(4), 573-587.

Fabrigar, L. R., Wegener, D. T., MacCallum, R. C., & Strahan, E. J. (1999). Evaluating the use of exploratory factor analysis in psychological research. *Psychological methods, 4*(3), 272.

Fish, R., Woodward, S., & Duperouzel, H. (2012). 'Change can only be a good thing:'staff views on the introduction of a harm minimisation policy in a Forensic Learning Disability service. *British Journal of Learning Disabilities, 40*(1), 37-45.

Fitzgerald, T. (2007). Documents and documentary analysis: reading between the lines. In M. C. Ann R J Briggs (Ed.), *Research methods in educational leadership and management* (pp. 278-294). London: SAGE Publications.

Fletcher, E., & Stevenson, C. (2001). Launching the Tidal Model in an adult mental health programme. *Nursing Standard, 15*(49), 33-36.

Fliege, H., Lee, J.-R., Grimm, A., & Klapp, B. F. (2009). Risk factors and correlates of deliberate self-harm behavior: A systematic review. *Journal of psychosomatic research, 66*(6), 477-493.

Flood, C., Bowers, L., & Parkin, D. (2008). Estimating the costs of conflict and containment on adult acute inpatient psychiatric wards. *Nursing Economics, 26*(5), 325-330.

Foster, C., Bowers, L., & Nijman, H. (2007). Aggressive behaviour on acute psychiatric wards: prevalence, severity and management. *Journal of advanced nursing, 58*(2), 140-149.

Friedman, T., Newton, C., Coggan, C., Hooley, S., Patel, R., Pickard, M., & Mitchell, A. J. (2006). Predictors of A&E staff attitudes to self-harm patients who use self-laceration: Influence of previous training and experience. *Journal of psychosomatic research, 60*(3), 273-277.

Fry, A. J., O'Riordan, D., Turner, M., & Mills, K. L. (2002). Survey of aggressive incidents experienced by community mental health staff. *International Journal of Mental Health Nursing, 11*(2), 112-120.

Gagnon, J., & Hasking, P. A. (2012). Australian psychologists' attitudes towards suicide and self-harm. *Australian Journal of Psychology, 64*(2), 75-82.

Gardner, A. R., & Gardner, A. J. (1975). Self-mutilation, obsessionality and narcissism. *British Journal of Psychiatry, 127*, 127-132.

Gibb, S. J., Beautrais, A. L., & Surgenor, L. J. (2010). Health-care staff attitudes towards self-harm patients. *Australian and New Zealand Journal of Psychiatry, 44*(8), 713-720.

Glenn, C. R., & Klonsky, E. D. (2010). The Role of seeing blood in non-suicidal self-injury. *Journal of Clinical Psychology, 66*(4), 466-473.

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse education today, 24*(2), 105-112.

Grunebaum, H., & Klerman, G. (1967). Wrist-slashing. *American Journal of Psychaitry, 124*, 527-534.

Guba, E. G. (1987). Naturalistic evaluation. *New directions for program evaluation, 1987*(34), 23-43.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods, 18*(1), 59-82.

Gutridge, K. (2010). Safer self-injury or assisted self-harm? *Theoretical medicine and bioethics, 31*(1), 79-92.

Hadfield, J., Brown, D., Pembroke, L., & Hayward, M. (2009). Analysis of accident and emergency doctors' responses to treating people who self-harm. *Qualitative Health Research, 19*(6), 755-765.

Haines, J., Williams, C. L., Brain, K. L., & Wilson, G. V. (1995). The psychophysiology of self-mutilation. *Journal of abnormal psychology, 104*(3), 471-489.

Hair, J. F., Tatham, R. L., Anderson, R. E., & Black, W. (2006). *Multivariate data analysis* (Vol. 6). Upper Saddle River, NJ: Pearson Prentice Hall

Hammersley, M. (1990). *Reading ethnographic research: A critical guide*: Longman.

Harris, J. (2000). Self-harm: Cutting the bad out of me. *Qualitative Health Research, 10*(2), 164-173.

Hauck, J. L., Harrison, B. E., & Montecalvo, A. L. (2013). Psychiatric nurses' attitudes toward patients with borderline personality disorder experiencing deliberate self-harm. *Journal of psychosocial nursing and mental health services, 51*(1), 20-29.

Haw, C., Hawton, K., Houston, K., & Townsend, E. (2001). Psychiatric and personality disorders in deliberate self-harm patients. *The British Journal of Psychiatry, 178*(1), 48-54.

Hawton, K., Bergen, H., Casey, D., Simkin, S., Palmer, B., Cooper, J., . . . Lilley, R. (2007). Self-harm in England: a tale of three cities. *Social psychiatry and psychiatric epidemiology, 42*(7), 513-521.

Hawton, K., Bergen, H., Cooper, J., Turnbull, P., Waters, K., Ness, J., & Kapur, N. (2015). Suicide following self-harm: Findings from the Multicentre Study of Self-harm in England, 2000–2012. *Journal of Affective Disorders*.

Hawton, K., & Fagg, J. (1988). Suicide, and other causes of death, following attempted suicide. *The British Journal of Psychiatry, 152*(3), 359-366.

Hawton, K., Fagg, J., Simkin, S., Bale, E., & Bond, A. (1997). Trends in deliberate self-harm in Oxford, 1985-1995. Implications for clinical services and the prevention of suicide. *The British Journal of Psychiatry, 171*(6), 556-560.

Hawton, K., Hall, S., Simkin, S., Bale, L., Bond, A., Codd, S., & Stewart, A. (2003). Deliberate self-harm in adolescents: a study of characteristics and trends in Oxford, 1990–2000. *Journal of Child Psychology and Psychiatry, 44*(8), 1191-1198.

Hawton, K., Harriss, L., Hall, S., Simkin, S., Bale, E., & Bond, A. (2003). Deliberate self-harm in Oxford, 1990–2000: a time of change in patient characteristics. *Psychological medicine, 33*(06), 987-995.

Hawton, K., Linsell, L., Adeniji, T., Sariaslan, A., & Fazel, S. (2014). Self-harm in prisons in England and Wales: an epidemiological study of prevalence, risk factors, clustering, and subsequent suicide. *The Lancet, 383*(9923), 1147-1154.

Hawton, K., Rodham, K., Evans, E., & Weatherall, R. (2002). Deliberate self harm in adolescents: self report survey in schools in England. *Bmj, 325*(7374), 1207-1211.

Hawton, K. K., Townsend, E., Arensman, E., Gunnell, D., Hazell, P., House, A., & Van Heeringen, K. (2015). Psychosocial and pharmacological treatments for deliberate self harm. *The Cochrane Library*.

Health and Social Care Information Centre. (2014). Mental Health Bulletin: Annual Report from MHMDS Returns 2013-14: Health and Social Care Information Centre.

Healthcare Commission. (2008). The pathway to recovery: a review of NHS acute inpatient mental health services. *Healthcare Commission*.

Heneghan, C., Wright, J., & Watson, G. (2013). Clinical Psychologists' Experiences of Reflective Staff Groups in Inpatient Psychiatric Settings: A Mixed Methods Study. *Clinical psychology & psychotherapy*.

Herpertz, S. (1995). Self-injurious behaviour Psychopathological and nosological characteristics in subtypes of self-injurers. *Acta Psychiatrica Scandinavica, 91*(1), 57-68.

Hill, C., & Watkins, J. (2003). Statutory health assessments for looked-after children: what do they achieve? *Child: Care, Health and Development, 29*(1), 3-13.

Hill, C. D., Rogers, R., & Bickford, M. E. (1996). Predicting Aggressive and Socially Disruptive Behaviour in a Maximum Security Forensic Psychiatric Hospital. *Journal of Forensic Sciences, 41(1): Jan 1996: 56-59*.

Hillbrand, M. (1992). Self-directed and other-directed aggressive behaviour in a foresnic sample. *Suicide and Life-Threatening Behaviour, 22*, 333-340.

Hillbrand, M. (1995). Aggression against self and aggression against others in violent psychiatric patients. *Journal of Consulting & Clinical Psychology, 63*(4), 668-671.

Hillbrand, M., Krystal, J. H., Sharpe, K. S., & Foster, H. G. (1994). Clinical predictors of self-mutilation in hospiotalised forensic patients. *Journal of Nervous and Mental Disease, 182(1),Jan,pp9-13*.

Hillbrand, M., Young, J. L., & Krystal, J. H. (1996). Recurrent self-injurious behavior in forensic patients. *Psychiatric Quarterly, 67*(1), 33-45.

Holley, C., Horton, R., Cartmail, L., & Bradley, E. (2012). Self-injury and harm minimisation on acute wards. *Nursing Standard, 26*(38), 51-56.

Horsfall, J., & Cleary, M. (2000). Discourse analysis of an 'observation levels' nursing policy. *Journal of advanced nursing, 32*(5), 1291-1297.

Huband, N., & Tantam, D. (2000). Attitudes to self-injury within a group of mental health staff. *British Journal of Medical Psychology, 73*(4), 495-504.

Huber, P. J. (1967). *The behavior of maximum likelihood estimates under nonstandard conditions.* Paper presented at the Proceedings of the fifth Berkeley symposium on mathematical statistics and probability.

Hume, M., & Platt, S. (2007). Appropriate interventions for the prevention and management of self-harm: a qualitative exploration of service-users' views. *BMC public health, 7*(1), 9.

Inglehart, R., & Baker, W. E. (2000). Modernization, cultural change, and the persistence of traditional values. *American sociological review*, 19-51.

Jackson, N. (2000). The prevalence and frequency of deliberate self-harm among male patients in a maximum secure hospital. *Criminal Behaviour & Mental Health, 10*(1), 21-28.

Jenkins, R., & Elliott, P. (2004). Stressors, burnout and social support: nurses in acute mental health settings. *Journal of advanced nursing, 48*(6), 622-631.

Joffe, H. (2011). Thematic analysis. In D. Harper & A. R. Thompson (Eds.), *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners* Chichester, UK: John Wiley & Sons.

Johnson, J. G., Cohen, P., Gould, M. S., Kasen, S., Brown, J., & Brook, J. S. (2002). Childhood adversities, interpersonal difficulties, and risk for suicide attempts during late adolescence and early adulthood. *Archives of general psychiatry, 59*(8), 741-749.

Johnson, R. B., & Onwuegbuzie, A. J. (2004). Mixed methods research: A research paradigm whose time has come. *Educational researcher, 33*(7), 14-26.

Johnson, R. B., Onwuegbuzie, A. J., & Turner, L. A. (2007). Toward a definition of mixed methods research. *Journal of mixed methods research, 1*(2), 112-133.

Joiner, T. (2005). *Why people die by suicide*: Harvard University Press.

Karson, C., & Bigelow, L. (1987). Violent behaviour in schizophrenic inpatients. *Journal of Nervous Mental Disorders, 175*, 161-164.

Kiess, H. O., & Bloomquist, D. W. (1985). *Psychological research methods: A conceptual approach*: Allyn & Bacon.

Kline, P. (1986). *A handbook of test construction: Introduction to psychometric design*: Methuen.

Klonsky, E. (2011). Non-suicidal self-injury in United States adults: prevalence, sociodemographics, topography and functions. *Psychological medicine, 41*(09), 1981-1986.

Klonsky, E. D. (2007). The functions of deliberate self-injury: A review of the evidence. *Clinical Psychology Review, 27*(2), 226-239.

Klonsky, E. D. (2009). The functions of self-injury in young adults who cut themselves: Clarifying the evidence for affect-regulation. *Psychiatry research, 166*(2), 260-268.

Klonsky, E. D., & Moyer, A. (2008). Childhood sexual abuse and non-suicidal self-injury: meta-analysis. *The British Journal of Psychiatry, 192*(3), 166-170.

Klonsky, E. D., Oltmanns, T. F., & Turkheimer, E. (2003). Deliberate self-harm in a nonclinical population: Prevalence and psychological correlates. *American Journal of Psychiatry, 160*(8), 1501.

Knowles, S., & Townsend, E. (2012). Implicit and explicit attitudes toward self harm: Support for a functional model. *Journal of behavior therapy and experimental psychiatry, 43*(2), 730-736.

Kodaka, M., Poštuvan, V., Inagaki, M., & Yamada, M. (2011). A systematic review of scales that measure attitudes toward suicide. *International journal of social psychiatry, 57*(4), 338-361.

Kool, N., van Meijel, B., Koekkoek, B., van der Bijl, J., & Kerkhof, A. (2014). Improving communication and practical skills in working with inpatients who self-harm: a pre-test/post-test study of the effects of a training programme. *BMC psychiatry, 14*(1), 64.

Krippendorff, K. (1980). *Content analysis: An introduction to its methodology*. Newbury Park: SAGE Publications.

Krosnick, J. A., & Fabrigar, L. R. (2001). *Designing Good Questionnaires: Insights from Cognitive and Social Psychology*: New York: Oxford University Press.

Kuiper, R. (2001). Enhancing metacognition through the reflective use of self-regulated learning strategies. *Journal of Continuing Education in Nursing, 33*(2), 78-87.

Langan, C., & McDonald, C. (2008). Daytime night attire as a therapeutic intervention in an acute adult psychiatric inpatient unit. *Psychiatric Bulletin, 32*(6), 221-223.

Langbehn, D. R., & Pfohl, B. (1993). Clinical correlates of self-mutilation among psychiatric inpatients. *Annals of Clinical Psychiatry, 5*(1), 45-51.

Lautenschlager, G. J., & Flaherty, V. L. (1990). Computer administration of questions: More desirable or more social desirability? *Journal of Applied Psychology, 75*(3), 310.

Lee, H. K., Villar, O., Juthani, N., & Bluestone, H. (1989). Characteristics and behaviour of patients involved in psychiatric ward incidents. *Hospital and Community Psychiatry, 40*(12), 1295-1297.

Likert, R. (1932). A technique for the measurement of attitudes. *Archives of psychology*.

Lindgren, B.-M., Öster, I., Åström, S., & Graneheim, U. H. (2011). 'They don't understand… you cut yourself in order to live.'Interpretative repertoires jointly constructing interactions between adult women who self-harm and professional caregivers. *International journal of qualitative studies on health and well-being, 6*(3).

Lindholm, T., Bjärehed, J., & Lundh, L.-G. (2011). Functions of nonsuicidal self-injury among young women in residential care: a pilot study with the Swedish version of the inventory of statements about self-injury. *Cognitive behaviour therapy, 40*(3), 183-189.

Low, G., Jones, D., Duggan, C., Power, M., & MacLeod, A. (2001). The treatment of deliberate self-harm in borderline personality disorder using dialectical behaviour therapy: A pilot study in a high security hospital. *Behavioural and cognitive psychotherapy, 29*(01), 85-92.

Low, G., Terry, G., Duggan, C., MacLeod, A., & Power, M. (1997). Deliberate self-harm among female patients at a special hospital: an incidence study. *Health Trends, 29*(1), 6-9.

Machin, T., & Westrip, S. (2013). Counselling approaches *The Art And Science Of Mental Health Nursing: Principles And Practice: A Textbook of Principles and Practice.* : McGraw-Hill International.

Mackay, N., & Barrowclough, C. (2005). Accident and emergency staff's perceptions of deliberate self-harm: Attributions, emotions and willingness to help. *British Journal of Clinical Psychology, 44*(2), 255-267.

Manley, K., Hills, V., & Marriot, S. (2011). Person-centred care: principle of nursing practice D. *Nursing Standard, 25*(31), 35-37.

Mann, J. J., Apter, A., Bertolote, J., Beautrais, A., Currier, D., Haas, A., . . . Marusic, A. (2005). Suicide prevention strategies: a systematic review. *Jama, 294*(16), 2064-2074.

Mannion, A. (2009). Self-harm in a dangerous and severely personality disordered population. *Journal of Forensic Psychiatry & Psychology, 20*(2), 322-331.

Martin, C., & Chapman, R. (2013). A mixed method study to determine the attitude of Australian emergency health professionals towards patients who present with deliberate self-poisoning. *International emergency nursing*.

Mathers, B. (2012). Acute mental health nurses: comprehensive practitioners or specialist therapists? *Journal of psychiatric and mental health nursing, 19*(1), 47-52.

Mays, N., & Pope, C. (2000). Assessing quality in qualitative research. *Bmj, 320*(7226), 50-52.

McAllister, M., Creedy, D., Moyle, W., & Farrugia, C. (2002). Nurses' attitudes towards clients who self-harm. *Journal of advanced nursing, 40*(5), 578-586.

McCarthy, L., & Gijbels, H. (2010). An examination of emergency department nurses' attitudes towards deliberate self-harm in an Irish teaching hospital. *International emergency nursing, 18*(1), 29-35.

McHale, J., & Felton, A. (2010). Self-harm: what's the problem? A literature review of the factors affecting attitudes towards self-harm. *Journal of psychiatric and mental health nursing, 17*(8), 732-740.

Mehrabian, A., & Russell, J. A. (1974). *An approach to environmental psychology*: MIT Press.

Meltzer, H., Lader, D., Corbin, T., Singleton, N., Jenkins, R., & Brugha, T. (2002). *Non-fatal suicidal behaviour among adults aged 16 to 74 in Great Britain*: Stationery Office.

Mind. (2004). Ward watch: Mind's campaign to improve hospital conditions for mental health patients. London: Mind.

Modestin, J., & Kamm, A. (1990). Parasuicide in psychiatric inpatients: Results of a controlled investigation. *Acta Psychiatrica Scandinavica, 81*(3), 225-230.

Moran, P., Coffey, C., Romaniuk, H., Olsson, C., Borschmann, R., Carlin, J. B., & Patton, G. C. (2012). The natural history of self-harm from adolescence to young adulthood: a population-based cohort study. *The Lancet, 379*(9812), 236-243.

Morgan, D. L. (2007). Paradigms lost and pragmatism regained methodological implications of combining qualitative and quantitative methods. *Journal of mixed methods research, 1*(1), 48-76.

Muehlenkamp, J., Brausch, A., Quigley, K., & Whitlock, J. (2013). Interpersonal features and functions of nonsuicidal self-injury. *Suicide and Life-Threatening Behavior, 43*(1), 67-80.

Muehlenkamp, J. J. (2005). Self-injurious behavior as a separate clinical syndrome. *American Journal of Orthopsychiatry, 75*(2), 324.

Muehlenkamp, J. J., Claes, L., Havertape, L., & Plener, P. L. (2012). International prevalence of adolescent non-suicidal self-injury and deliberate self-harm. *Child and adolescent psychiatry and mental health, 6*(10), 1-9.

Muehlenkamp, J. J., & Gutierrez, P. M. (2007). Risk for suicide attempts among adolescents who engage in non-suicidal self-injury. *Archives of suicide research, 11*(1), 69-82.

Myers, K., & Dunner, D. (1984). Self and other directed violence on a closed acute care ward. *Psychiatric Quarterly, 56*, 178-188.

National institute for Health and Care Excellence. (2011). *Self-harm: longer-term management (Clinical guideline CG133.)*. http://www.nice.org.uk/guidance/CG133: NICE.

National Patient Safety Agency. (2014). National Reporting and Learning System eform. from http://www.nrls.npsa.nhs.uk/report-a-patient-safety-incident/

Neuner, T., Schmid, R., Wolfersdorf, M., & Spiebl, H. (2008). Predicting inpatient suicides and suicide attempts by using clinical and routine data? *General Hospital Psychiatry, 30*, 324-330.

Niedtfeld, I., Schulze, L., Kirsch, P., Herpertz, S. C., Bohus, M., & Schmahl, C. (2010). Affect regulation and pain in borderline personality disorder: a possible link to the understanding of self-injury. *Biological psychiatry, 68*(4), 383-391.

Nijman, H., Bowers, L., Oud, N., & Jansen, G. (2005). Psychiatric nurses' experience with inpatient aggression. *Aggressive Behavior, 31*(3), 217-227.

Nijman, H., & Campo, J. (2002). Situational Determinants of Inpatient Self-Harm. *Suicide and Life-Threatening Behavior, 32*(2), 167-175.

Nock, M. K. (2008). Actions speak louder than words: An elaborated theoretical model of the social functions of self-injury and other harmful behaviors. *Applied and Preventive Psychology, 12*(4), 159-168.

Nock, M. K., Joiner, T. E., Gordon, K. H., Lloyd-Richardson, E., & Prinstein, M. J. (2006). Non-suicidal self-injury among adolescents: Diagnostic correlates and relation to suicide attempts. *Psychiatry research, 144*(1), 65-72.

Nock, M. K., & Mendes, W. B. (2008). Physiological arousal, distress tolerance, and social problem-solving deficits among adolescent self-injurers. *Journal of consulting and clinical psychology, 76*(1), 28.

Nock, M. K., & Prinstein, M. J. (2004). A functional approach to the assessment of self-mutilative behavior. *Journal of consulting and clinical psychology, 72*(5), 885.

Nunnally, J. C., Bernstein, I. H., & Berge, J. M. t. (1967). *Psychometric theory* (Vol. 226): McGraw-Hill New York.

O'Carroll, P. W., Berman, A. L., Maris, R. W., Moscicki, E. K., Tanney, B. L., & Silverman, M. M. (1996). Beyond the Tower of Babel: a nomenclature for suicidology. *Suicide and Life-Threatening Behavior, 26*(3), 237-252.

O'Cathain, A., Murphy, E., & Nicholl, J. (2007). Why, and how, mixed methods research is undertaken in health services research in England: a mixed methods study. *BMC health services research, 7*(1), 85.

O'Connor, R. C., Rasmussen, S., & Hawton, K. (2009). Predicting Deliberate Self-Harm in Adolescents: A Six Month Prospective Study. *Suicide and Life-Threatening Behavior, 39*(4), 364-375.

O'Donovan, A. (2007). Pragmatism rules: the intervention and prevention strategies used by psychiatric nurses working with non-suicidal self-harming individuals. *Journal of psychiatric and mental health nursing, 14*, 64-71.

O'Donovan, A., & Gijbels, H. (2006). Understanding psychiatric nursing care with nonsuicidal self-harming patients in acute psychiatric admission units: The views of psychiatric nurses. *Archives of psychiatric nursing, 20*(4), 186-192.

O'Shea, L. E., Picchioni, M. M., Mason, F. L., Sugarman, P. A., & Dickens, G. L. (2014). Predictive validity of the HCR-20 for inpatient self-harm. *Comprehensive psychiatry, 55*(8), 1937-1949.

Office for National Statistics, 2011 Census: Aggregate data (England and Wales. (2011). Retrieved from: http://infuse.mimas.ac.uk

Oldershaw, A., Richards, C., Simic, M., & Schmidt, U. (2008). Parents' perspectives on adolescent self-harm: Qualitative study. *The British Journal of Psychiatry, 193*(2), 140-144.

Oppenheim, A. N. (2000). *Questionnaire design, interviewing and attitude measurement*: Continuum International Publishing Group.

Orlando, C.M., Broman-Fulks, J.J., Whitlock, J.L., Curtin, L, & Michael, K.D. (2015). Nonsuicidal self-injury and suicidal self-injury: A taxometric investigation. Behaviour Therapy. *In Press.*

Osafo, J., Knizek, B., Akotia, C. S., & Hjelmeland, H. (2013). Influence of religious factors on attitudes towards suicidal behaviour in Ghana. *Journal of religion and health, 52*(2), 488-504.

Pan, Y., & Jackson, R. (2008). Ethnic difference in the relationship between acute inflammation and serum ferritin in US adult males. *Epidemiology and infection, 136*(03), 421-431.

Pao, P. N. (1969). The syndrome of delicate self-cutting. *British Journal of Medical Psychology, 42*(195), 867-872.

Parkes, J. (2003). The nature and management of aggressive incidents in a medium secure unit. *Medicine, science and the law, 43*(1), 69-74.

Patterson, P., Whittington, R., & Bogg, J. (2007a). Measuring nurse attitudes towards deliberate self-harm: the Self-Harm Antipathy Scale (SHAS). *Journal of psychiatric and mental health nursing, 14*(5), 438-445.

Patterson, P., Whittington, R., & Bogg, J. (2007b). Testing the effectiveness of an educational intervention aimed at changing attitudes to self-harm. *Journal of psychiatric and mental health nursing, 14*(1), 100-105.

Patton, M. Q. (1990). *Qualitative evaluation and research methods*: SAGE Publications.

Paul, E., Tsypes, A., Eidlitz, L., Ernhout, C., & Whitlock, J. (2014). Frequency and Functions of non-suicidal self-injury: Associations with suicidal thoughts and behaviors. *Psychiatry research, 225*(5), 276-282.

Pedhazur, E. J., & Schmelkin, L. P. (2013). *Measurement, design, and analysis: An integrated approach*: Psychology Press.

Pembroke, L. (1994). Self Harm: Perspectives from Personal Experience. London.

Pembroke, L. (2009). Cutting the risk. London.

Perry, I.J., Corcoran, P., Fitzgerald, A.P., Keeley, H.S., Reulbach, U., & Arensman, E (2012). The incidence and repetition of hospital-treated deliberate self harm: Findings from the world's first national registry*. PLoS ONE,* 7(2)*.*

Pirkis, J., Burgess, P., & Jolley, D. (1999). Suicide attempts by psychiatric patients in acute inpatient, long-stay inpatient, and community care. *Social psychiatry and psychiatric epidemiology, 34*, 636-644.

Plutchik, R. (1995). Outward and inward directed aggressiveness: the interaction between violence and suicidality. *Pharmacopsychiatry*.

Ramon, S., & Breyter, C. (1978). Attitudes towards self-poisoning among British and Israeli doctors and nurses in a psychiatric hospital. *Israel Annals of Psychiatry & Related Disciplines*.

Reece, J. (2005). The language of cutting: Initial reflections on a study of the experiences of self-injury in a group of women and nurses. *Issues in Mental Health Nursing, 26*(6), 561-574.

Riley, D., Sawka, E., Conley, P., Hewitt, D., Mitic, W., Poulin, C., . . . Topp, J. (1999). Harm reduction: Concepts and practice. A policy discussion paper. *Substance use & misuse, 34*(1), 9-24.

Rinzler, C., & Shapiro, D. (1968). Wrist-cutting and suicide. *Journal of the Mount Sinai Hospital, 35*, 485-488.

Roach, P., Duxbury, J. A., Wright, K., Bradley, D., & Neil, H. (2009). Conducting research on acute mental health admission wards. *Nurse researcher, 16*(4), 65.

Roaldset, J. O. B. S. (2010). Patients' own statements of their future risk for violent and self-harm behaviour: A propspective inpatient and post-discharge follow-up study in an acute psychiatric unit. *Psychiatry research, 178*, 153-159.

Robinson, J. P., Shaver, P. R., & Wrightsman, L. S. (1991). Criteria for scale selection and evaluation. *Measures of personality and social psychological attitudes, 1*(3), 1-16.

Robson, C. (2002). *Real word research*: Oxford: Blackwell.

Rodham, K., Hawton, K., & Evans, E. (2004). Reasons for deliberate self-harm: Comparison of self-poisoners and self-cutters in a community sample of adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*(1), 80-87.

Rosenthal, R. J., Rinzler, C., Wallsh, R., & Klausner, E. (1972). Wrist-cutting syndrome: the meaning of a gesture. *American Journal of Psychiatry, 128*(11), 1363.

Royal College of Psychiatrists. (2010). Self-Harm, Suicide and Risk: Helping People who Self-Harm (College Report CR158). London.

Royal College of Psychiatrists. (2011). Do the Right Thing: How to Judge a Good Ward. Ten standards for adult in-patient mental healthcare. *Occasional Paper OP79*. London.

Rubin, D. B. (2004). *Multiple imputation for nonresponse in surveys* (Vol. 81): John Wiley & Sons.

Rygnestad, T. (1988). A prospective 5-year follow-up study of self-poisoned patients. *Acta Psychiatrica Scandinavica, 77*(3), 328-331.

Sakinofsky, I. (2000). Repetition of suicidal behaviour *The international handbook of suicide and attempted suicide* (pp. 385-404): John Wiley & Sons.

Sandy, P. (2013). Motives for self-harm: views of nurses in a secure unit. *International nursing review, 60*(3), 358-365.

Sandy, P. T., & Shaw, D. (2012). Attitudes of mental health nurses to self-harm in secure forensic settings: a multi-method phenomenological investigation. *Journal of Medicine and Medical Science Research, 1*(4), 63-75.

Saraff, P. D., & Pepper, C. M. (2014). Functions, lifetime frequency, and variety of methods of non-suicidal self-injury among college students. *Psychiatry research, 219*(2), 298-304.

Sari, A. B.-A., Sheldon, T. A., Cracknell, A., & Turnbull, A. (2007). Sensitivity of routine system for reporting patient safety incidents in an NHS hospital: retrospective patient case note review. *British Medical Journal, 334*(7584), 79.

Sayal, K., Yates, N., Spears, M., & Stallard, P. (2014). Service use in adolescents at risk of depression and self-harm: prospective longitudinal study. *Social psychiatry and psychiatric epidemiology, 49*(8), 1231-1240.

Schmidtke, A., Bille Brahe, U., DeLeo, D., Kerkhof, A., Bjerke, T., Crepef, P., . . . Michel, K. (1996). Attempted suicide in Europe: rates, trend. S and sociodemographic characteristics of suicide attempters during the period 1989–1992. Results of the WHO/EURO Multicentre Study on Parasuicide. *Acta Psychiatrica Scandinavica, 93*(5), 327-338.

Schoppmann, S., Schröck, R., Schnepp, W., & Büscher, A. (2007). 'Then I just showed her my arms...'Bodily sensations in moments of alienation related to self-injurious behaviour. A hermeneutic phenomenological study. *Journal of psychiatric and mental health nursing, 14*(6), 587-597.

Schreiber, J. B., Nora, A., Stage, F. K., Barlow, E. A., & King, J. (2006). Reporting structural equation modeling and confirmatory factor analysis results: A review. *The Journal of Educational Research, 99*(6), 323-338.

Scoliers, G., Portzky, G., Madge, N., Hewitt, A., Hawton, K., De Wilde, E. J., . . . Fekete, S. (2009). Reasons for adolescent deliberate self-harm: a cry of pain and/or a cry for help? *Social psychiatry and psychiatric epidemiology, 44*(8), 601-607.

Scott, J. (1990). *A matter of record: Documentary sources in social research*: Polity Press Cambridge.

Scriven, M. P., R. (1987). Paper presented at the 8th Annual International Conference on Critical Thinking and Education Reform.

Seale, C. (1999). Quality in qualitative research. *Qualitative inquiry, 5*(4), 465-478.

Seale, C., Gobo, G., Gubrium, J. F., & Silverman, D. (2004). *Qualitative research practice*: Sage.

Sharac, J., McCrone, P., Sabes-Figuera, R., Csipke, E., Wood, A., & Wykes, T. (2010). Nurse and patient activities and interaction on psychiatric inpatients wards: a literature review. *International Journal of Nursing Studies, 47*(7), 909-917.

Shearer, S. L. (1994). Phenomenology of self-injury among inpatient women with boderline personality disorder. *Journal of Nervous and Mental Disease*.

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for information, 22*(2), 63-75.

Silverman, D. (2011). *Interpreting qualitative data*: Sage.

Silverman, M. M., Berman, A. L., Sanddal, N. D., O'Carroll, P. W., & Joiner, T. E. (2007). Rebuilding the tower of Babel: a revised nomenclature for the study of suicide and suicidal behaviors part 2: suicide-related ideations, communications, and behaviors. *Suicide and Life-Threatening Behavior, 37*(3), 264-277.

Simpson, A., Jones, J., Barlow, S., L, C., & Service User and Carer Group Advising on Research (SUGAR). (2014). Adding SUGAR: Service User and Carer Collaboration in Mental Health Nursing Research. *Journal of psychosocial nursing and mental health services, 52*(1), 22-30.

Sinclair, J. M., Gray, A., Rivero-Arias, O., Saunders, K. E., & Hawton, K. (2011). Healthcare and social services resource use and costs of self-harm patients. *Social psychiatry and psychiatric epidemiology, 46*(4), 263-271.

Smith, K., Conroy, R., & Ehler, B. (1984). Lethality of suicide attempt rating scale. *Suicide and Life-Threatening Behavior, 14*(4), 215-242.

Smith, S. (2002). Perceptions of service provision for clients who self injure in the absence of expressed suicidal intent. *Journal of psychiatric and mental health nursing, 9*(5), 595-601.

Sorgi, P., Ratey, J., Knoedler, D. W., Market, R. J., & Reichman, M. (1991). Rating aggression in the clinical setting: a retrospective adaptation of the overt aggression scale: preliminary results. *Journal of Neuropsychiatry, 3*(2), 52-56.

Spiebl, H., Hubner-Liebermann, B., & Cording, C. (2002). Suicidal behaviour of psychiatric in-patients. *Acta Psychiatric Scandinavica, 106*, 134-138.

Stack, S. (1998). Heavy metal, religiosity, and suicide acceptability. *Suicide and Life-Threatening Behavior, 28*(4), 388-394.

Stack, S., & Kposowa, A. J. (2008). The Association of Suicide Rates with Individual-Level Suicide Attitudes: A Cross-National Analysis. *Social Science Quarterly, 89*(1), 39-59.

Stack, S., & Kposowa, A. J. (2011a). The effect of survivalism–self-expressionism culture on black male suicide acceptability: A cross-national analysis. *Social Science & Medicine, 72*(7), 1211-1218.

Stack, S., & Kposowa, A. J. (2011b). Religion and Suicide Acceptability: A Cross-National Analysis. *Journal for the scientific study of religion, 50*(2), 289-306.

Stewart, D., Bowers, L., & Warburton, F. (2009). Constant special observation and self-harm on acute psychiatric wards: a longitudinal analysis. *General Hospital Psychiatry, 31*(6), 523-530.

Stewart, D., Ross, J., Watson, C., James, K., & Bowers, L. (2011). Patient characteristics and behaviours associated with self-harm and attempted suicide on acute psychiatric wards. *Journal of Clinical Nursing, 21*, 1004-1013.

Streiner, D. L., & Norman, G. R. (2008). *Health measurement scales: a practical guide to their development and use*: Oxford university press.

Sun, F. K., Long, A., & Boore, J. (2007). The attitudes of casualty nurses in Taiwan to patients who have attempted suicide. *Journal of Clinical Nursing, 16*(2), 255-263.

Sunak, R., Rajeswaran, S. (2014). A portrait of modern britain. London.

Suokas, J., & Lönnqvist, J. (1991). Outcome of attempted suicide and psychiatric consultation: risk factors and suicide mortality during a five-year follow-up. *Acta Psychiatrica Scandinavica, 84*(6), 545-549.

Sweeny, R., & Zamecnik, K. (1981). Predictors of self-mutilation in patients with schizophrenia. *American Journal of Psychaitry, 138*(8), 1086-1089.

Swinton, M., & Hopkins, R. (1996). Violence and Self-injury. *Journal of Forensic Psychiatry, 7*(3), 563-569.

Swinton, M., Hopkins, R., & Swinton, J. (1998). Reports of self-injury in a maximum security hospital. *Criminal Behaviour & Mental Health., 8*(1), 7-16.

Tabachnick, B. G., & Fidell, L. (2005). *Using Multivariate Statistics* (5 ed.): Pearson.

Tashakkori, A., & Teddlie, C. (2003). The past and future of mixed methods research: From data triangulation to mixed model designs. In A. Tashakkori & C. Teddlie (Eds.), *Handbook of mixed methods in social and behavioral research* (pp. 671-701). London: SAGE Publications.

Taylor, T. L., Hawton, K., Fortune, S., & Kapur, N. (2009). Attitudes towards clinical services among people who self-harm: systematic review. *The British Journal of Psychiatry, 194*(2), 104-110.

The NHS Information Centre. (2009). *Hospital Episode Statistics: Main specialty, 2008-2009*.

Thurstone, L. L. (1928). Attitudes can be measured. *American journal of Sociology*, 529-554.

Thurstone, L. L. (1931). The measurement of social attitudes. *The Journal of Abnormal and Social Psychology, 26*(3), 249.

Tobin, M., Lim, L., & Falkowshi, W. (1991). How do we manage violent behavior. *British Journal of Clinical and Social Psychiatry, 8*(1), 19-23.

Treloar, A. J. C. (2009). Effectiveness of education programs in changing clinicians' attitudes toward treating borderline personality disorder. *Psychiatric Services, 60*(8), 1128-1131.

Turner, D. W. (2010). Qualitative interview design: A practical guide for novice investigators. *The Qualitative Report, 15*(3), 754-760.

UK Central Council for Nursing Midwifery and Health Visiting. (1999). *Fitness for practice*: UKCC.

UK Clinical Research Network Study Portfolio. (2013). Safewards UK Clinical Research Network Study Portfolio http://public.ukcrn.org.uk/search/StudyDetail.aspx?StudyID=11269.

van der Ham, A. J., Shields, L. S., van der Horst, R., Broerse, J. E., & van Tulder, M. W. (2013). Facilitators and Barriers to Service User Involvement in Mental Health Guidelines: Lessons from The Netherlands. *Administration and Policy in Mental Health and Mental Health Services Research*, 1-12.

Ware Jr, J. E., & Sherbourne, C. D. (1992). The MOS 36-item short-form health survey (SF-36): I. Conceptual framework and item selection. *Medical care*, 473-483.

Way, B. B., & Banks, S. (2001). Clinical factors related to admission and release decisions in psychiatric emergency services. *Psychiatric Services, 52*(2), 214-218.

Weber, M. T. (2002). Triggers for self-abuse: A qualitative study. *Archives of psychiatric nursing, 16*(3), 118-124.

Wheatley, M., & Austin-Payne, H. (2009). Nursing staff knowledge and attitudes towards deliberate self-harm in adults and adolescents in an inpatient setting. *Behav Cogn Psychother, 37*(3), 293-309.

Whisenhunt, J. L., Changg, C., Brack, G., Orr, J., & Adams, L. (2012). *Professional Counselors' Conceptualizations of the Relationship between Suicide and Self-Injury.* (Doctor of Philosophy), Georgia State University.

Whitlock, J., & Knox, K. L. (2007). The relationship between self-injurious behavior and suicide in a young adult population. *Archives of pediatrics & adolescent medicine, 161*(7), 634-640.

Williams, S. K., & Osborn, S. S. (2006). The development of the national reporting and learning system in England and Wales, 2001-2005. *Medical journal of Australia, 184*(10), S65.

Wilstrand, C., Lindgren, B. M., Gilje, F., & Olofsson, B. (2007). Being burdened and balancing boundaries: a qualitative study of nurses' experiences caring for patients who self-harm. *Journal of psychiatric and mental health nursing, 14*(1), 72-78.

Zahl, D. L., & Hawton, K. (2004). Repetition of deliberate self-harm and subsequent suicide risk: long-term follow-up study of 11 583 patients. *The British Journal of Psychiatry, 185*(1), 70.

9. Appendices

APPENDIX A: Table of studies included in systematic review

Paper	Type of service	Country
Abidin, Z., Davoren, M., Naughton, L., Gibbons, O., Nulty, A & Kennedy, H.G (2013) Susceptibility (risk and protective) factors for in-patient violence and self-harm: prospective study of structured professional judgement instruments START and SAPROF, DUNDRUM-3 and DUNDRUM-4 in forensic mental health services. BMC Psychiatry, 13 (1), 197	Forensic	Ireland
Ahmed, A.G & Lepnurm, M. (2001). Seclusion practice in a Canadian forensic psychiatric hospital, Journal of American Academy of Psychiatry and Law, 29(3), 303-309.	Forensic	Canada
Ballinger, B (1971). Minor Self-Injury, British Journal of Psychiatry, 118, 535-538	Acute	UK
Bauer, R., Spiessl, H & Schmidt, T (2012) Are there associations between caregiver information and suicidal behavior in psychiatric inpatients? International Journal of Psychiatry in Clinical Practice, 16: 238–242	Acute	Germany
Beasley, S. (1999) Deliberate self harm in medium security. Nursing Management. 6(8), 29-33	Forensic	UK
Beer, D, M., Muthukumaraswamy, A., Khan, A, A., & Musabbir, M, A. (2010) Clinical characteristics of patients with self harming behaviour in a low secure mental health unit. Journal of Psychiatric Intensive Care, 6(15); 15-21	Acute	UK
Bellus, S.B., Vergo, J.G., Kost, P.P., Stewart, D & Barkstrom, S.R. (1999) Behavioural rehabilitation and the reduction of aggressive and self injurious behaviours with cognitively impaired, chronic psychiatric inpatients. Psychiatric Quarterly. 70(1), 27-37	Acute	USA
Bisconer,S.W., Green,M., Mallon-Czajka,J & Johnson,J.S.(2006). Managing aggression in a psychiatric hospital using a behaviour plan: a case study. Journal of psychiatric and mental health nursing, 13, 515-521.	Acute	USA
Booth, R., Keogh, K., Doyle, J & Owens, T. (2012) Living Through Distress: A Skills Training Group for Reducing Deliberate Self-Harm. Behavioural and Cognitive Psychotherapy,42, 156–165	Acute	Ireland
Bowers, L., Allan, T., Simpson, A., Nijman, H & Warren, J. (2007). Adverse incidents, patient flow and nursing workforce variables on acute psychiatric wards: The Tompkins acute ward study. International Journal of Social Psychiatry, 53(1), 75-84.	Acute	UK
Bowers, L., Brennan, G., Flood, C., Lipang, M & Oladapo, P. (2006) Preliminary outcomes of a trial to reduce conflict and containment on acute psychiatric wards: City Nurses. Journal of Psychiatric and Mental Health Nursing, 13, 165-172.	Acute	UK
Bowers, L., Douzenis, A., Galeazzi, G.M., Forghieri, M., Tsopelas, C., Simpson, A & Allan, T. (2005) Disruptive and dangerous behaviour by patients on acute psychiatric wards in three European centres. Social Psychiatry and Psychiatric Epidemiology, 40(10), 822-8.	Acute	UK, Greece, Italy
Bowers, L., Flood, C & Brennan, G. (2008) A replication study of the city nurse intervention: reducing conflict and containment on three acute psychiatric wards. Journal of Mental Health Nursing, 15, 737-742.	Acute	UK
Bowers, L., Gournay, K & Duffy, D. (2000) Suicide and self-harm in inpatient psychiatric units: a national survey of observation policies. Journal of Advanced Nursing, 32(2), 437-44.	Acute	UK

Bowers, L., James, K., Dack, C., Gul, N & Thomas, B (2011). Learning from prevented suicide in psychiatric inpatient care: An analysis of data from the National Patient Safety Agency. International Journal of Nursing Studies, 48(12), 1459-1465.	Acute	UK
Bowers, L., Simpson, A., & Alexander, J. (2003) Patient-staff conflict: results of a survey on acute psychiatric wards. Social Psychiatry and Psychiatric Epidemiology, 38(7), 402-408.	Acute	UK
Bowers, L., Whittington, R., Nolan, P., Parkin, D., Curtis, S., Bhui, K., Hackney, D., Allan, T & Simpson, A. (2008) Relationship between service ecology, special observation and self-harm during acute in-patient care: City-128 study. The British Journal of Psychiatry, 193(5), 395-401.	Acute	UK
Breeze, J.A., & Repper, J. (1998) Struggling for control: the care experienced of 'difficult' patients in mental health services. Journal of Advanced Nursing, 26(6), 1301-1311	Acute	UK
Brown, S & Bass, N. (2004) The psychiatric intensive care unit (PICU): Patients characteristics, treatment and outcome. Journal of Mental Health, 13(6), 601-609	Mixed	UK
Burrow, S. (1992) The deliberate self-harming behaviour of patients within a British special hospital. Journal of Advanced Nursing, 17, 138-148.	Forensic	UK
Callias, C.G & Carpenter, M.D. (1994) Self injurious behaviour in a state psychiatric hospital. Hospital and Community Psychiatry, 45(2), 170-172	Acute	USA
Carlen, P & Bengtsson, A. (2007) Suicidal patients as experienced by psychiatric nurses in inpatient care. International Journal of Mental Health, 16, 257-265.	Acute	Sweden
Chengappa, K, N, R., Ebeling, T., Kang, J, S., Levine, J & Parepally, H. (1999) Clozapine reduced severe self mutilation and aggression in psychotic patients with borderline personality disorder. Journal of Clinical Psychiatry, 60(7), 477-484	Acute	USA
Coons, P & Milstein, V. (1990) Self-mutilation associated with dissociative disorders. Dissociation, 3(2), 81-87	Acute	USA
Daffern, M & Howells, K (2009) Self-harm and aggression in dangerous and severely personality disordered patients of a high-security hospital. Psychiatry, Psychology and Law. 16(1), 150-154	Forensic	UK
Daffern, M & Howells, K. (2007) The prediction of imminent aggression and self-harm in personality disordered patients of a high security hospital using the HCR-20 clinical scale and the dynamic appraisal of situational aggression. International Journal of Forensic Mental Health. 6(2), 137-143.	Forensic	Australia
Daffern,M., Thomas,T., Ferguson,M., Podubinski, T., Hollander, Y., Kulkhani, J., deCastella, A., & Foley, F. (2010) The Impact of Psychiatric Symptoms, Interpersonal Style, and Coercion on Aggression and Self-Harm During Psychiatric Hospitalization. Psychiatry 73(4) 365-380.	Acute	Australia
Dooley, E. (1986) Aggressive incidents in a secure hospital. Medical Science Law. 26(2), 125-129.	Forensic	Ireland
Drew, B. (2001) Self-harm behaviour and no-suicide contracting in psychiatric inpatient settings. Archives of Psychiatric Nursing, 15(3), 99-106	Acute	USA
Ehmann, T.S., Smith, G.N., Yamamoto, A., McCArthy, N., Ross, D., Au, T., Flynn, S.W., Altman, S & Honer, W.G. (2001) Violence in treatment resistant psychotic inpatients. The Journal of Nervous and Mental Disease. 189(10), 716-721	Acute	Canada
Eisenhauer.G.L. (1985). Self-inflicted ocular removal by two psychiatric inpatients, Hospital and Community Psychiatry, 36(2), 189-191	Acute	USA

Fairlie, A. & Brown, R. (1994) Accidents and Incidents Involving Patients in a Mental Health Service. Journal of Advanced Nursing, 19, 864-869.	Mixed	UK
Fletcher, E & Stevenson, C. (2001) Launching the Tidal Model in an adult mental health programme. Nursing Standard, 15(49), 33-36	Acute	UK
Flood, C., Bowers, L, & Parkin, D. (2008) Estimating the costs of conflict and containment on adult acute inpatient psychaitric wards. Nurse Economics, 26(5), 325-330	Acute	UK
Foster,C.,Bowers,L., & Nijman,H. (2007). Aggressive behaviour on acute psychiatric wards: prevalence, severity and management, Journal of Advanced Nursing, 58(2), 140-149.	Acute	UK
Fottrell, E. (1980) A study of violent behaviour among patients in psychiatric hospitals. British Journal of Psychiatry, 136, 216-221.	Acute	UK
Fottrell, E., Bewley, T. & Squizzoni, M. (1978) A study of aggressive and violent behaviour among a group of psychiatric inpatients. Medicine, Science and the Law, 18(1), 66-69.	Acute	UK
Fresan, A., Apiquian, R., Fuente-Sandoval, C., Loyzaga, Garcia-Anaya, M., Meyenberg, N., & Nicolini, H. (2005). Violent behavior in schizophrenic patients: relationship with clinical symptoms. Aggressive Behavior, 21, 511-520.	Acute	Mexico
Gardner,A.R. & Gardner,A.J. (1975). Self-mutilation, obsessionality and narcissism, British Journl of Psychoatry, 127, 127-132	Acute	UK
Gibb, S,J., Beautrais, A,L.,& Surgenor, L,J. (2010). Health-Care Staff Attitudes Towards Self-Harm Patients. The Australian and New Zealand journal of psychiatry, 44, 713-720.	Acute	New Zealand
Goldberg, B. R., Seper, M. R., Sheets, M., Beech, D., Dill, C., & Duffy, K. G. (2007). Predictors of aggression on the psychiatric inpatient service: self-esteem, narcissism, and theory of mind deficits. Journal of Nervous and Mental Disease, 195 (5) 436-42.	Acute	USA
Gorenc, K.D & Bruner, C.A. (1985) Suicidal behaviour among patients in Bavarian mental hospitals. Acta Psychiatrica Scandinavica, 71, 468-478.	Acute	Germany
Gournay, K & Bowers, L. (2000) Suicide and self harm in in-patient psychiatric units: a study of nursing issues in 31 cases. Journal of Advanced Nursing, 32(1), 124-131	Unknown	UK
Grunebaum, H.U & Klerman, G.L. (1967) Wrist slashing. American Journal of Psychiatry. 124(4), 113-120	Acute	USA
Hauck JL, Harrison BE., & Montecalvo AL.(2013) Psychiatric nurses' attitudes toward patients with borderline personality disorder experiencing deliberate self-harm. Journal of psychosocial nursing and mental health services, 51(1), 20-29.	Acute	USA
Hayes, J., Gibbons, R., Outim, F., Tang, S & Chakraborty, A (2012) A new model for quality improvement in acute inpatient psychiatry: observational data from an acute assessment unit. Journal of the Royal Society of Medicine Short Reports, 65 (3), 1-8	Acute	UK
Hill, C, D., Rogers, R., & Bickford, M, E. (1995) Predicting aggressive and socially disruptive behaviour in a maximum security forensic psychiatric hospital. Journal of forensic Sciences. 41(1), 56-59	Forensic	USA
Hillbrand, M. (1992) Self-directed and other-directed aggressive behaviour in a forensic sample. Suicide and Life-Threatening Behaviour, 22(3), 333-340.	Forensic	USA

Hillbrand, M. (1995) Aggression against self and aggression against others in violent psychiatric patients. Journal of Consulting and Clinical psychology, 63(4), 668-671.	Forensic	USA
Hillbrand, M., Krystal, J.H, Sharpe, K.S & Foster, H.G. (1994) Clinical predictors of self-mutilation in hospitalized forensic patients. Journal of nervous and mental disease, 182(1), 9-13.	Forensic	USA
Hyde, C.E., Waller, G & Wyn-Pugh, E. (1992) Psychopathology and violent behaviour in psychiatric intensive care. Psychiatric Bulletin, 16, 536-537.	PICU	UK
Jackson,N. (2000). The prevalence and frequency of deliberate self-harm among male patients in a maximum secure hospital, Criminal Behaviour and Mental Health, 10, 21-28	Forensic	UK
Karson, C. & Bigelow, L. (1987) Violent behaviour in schizophrenic inpatients. The Journal of Nervous and Mental Disease, 175(3), 161-164.	Acute	USA
Kho, K., Sensky, T., Mortimer, A & Corcos, C. (1998) Prospective study into factors associated with aggressive incidents in psychiatric acute admission wards. British Journal of Psychiatry, 172, 38-43	Mixed	UK
Kool, N., Meijel, B., Koekkoek, B., Bikl, J & Kerkhof, A (2014) Improving communication and practical skills in working with inpatients who self-harm: a pretest/post-test study of the effects of a training programme. BMC Psychiatry, 64 (14)	Mixed	Netherlands
Kraus, J.E & Sheitman, B.B. (2004) Characteristics of violent behaviour in a large state psychiatric hospital.	Mixed	USA
Kroll, J.L. (1978). Self-destructive behaviour on an inpatient ward. Journal of Nervous and Mental Disease 166(6), 429-433	Acute	USA
Langan,C.& McDonald,C. (2008). Daytime night attire as a therapeutic intervention in an acute adult psychiatric inpatient unit, Psychiatric Bulletin, 32, 221-224	Acute	Ireland
Larkin, E, Murtagh, S & Jones, S. (1988) A preliminary study of violent incidents in a special hospital (Rampton), The British Journal of Psychiatry, 153, 226-231	Acute	UK
Lee, H, K., Villar, O., Juthani, N & Bluestone, H (1989). Characteristics and behaviour of patients involved in psychiatric ward incidents. Hospital and Community Psychiatry, 40(12), 1295-1297	Acute	USA
Leontieva, L & Gergory, R. (2013) Characteristies of patients with borderline personality disorder in a state psychiatric hospital. Journal of Personality Disorders, 27(2), 222-232	Acute	USA
Lindgren, B., Oster, I., Astrom, S & Graneheim, U. (2011) 'They don't understand…you cut yourself in order to live'. Interpretative repertoires jointy constructing interactions between adult women who self-harm and professional caregivers. International journal of qualitative studies on health and well-being, 6(3).	Acute	Sweden
Low, G., Jones, D & Duggan, C (2001). The treatment of deliberate self harm in borderline personality disorder using dialectical behaviour therapy: A pilot study in a high security hospital. Behavioural and Cognitive Psychotherapy. 29, 85-92	Forensic	UK
Low, G., Terry, G., Duggan, C., MacLeod, A & Power, M. (1997) Deliberate self-harm among female patients at a special hospital: an incidence study. Health Trends, 29(1), 6-9.	Forensic	UK
Mannion, A. (2009) Self-harm in a dangerous and severely personality disordered population. The Journal of Forensic Psychiatry and Psychology. 20(2), 322-331.	Forensic	UK

McKerracher,D.W., Loughnane,T., & Watson,R.A. (1968). Self-mutilation in female psychopaths, British Journal of Psychiatry,114, 829-832.	Forensic	UK
McLaughlin, C. (1999) An exploration of psychiatric nurses and patients opinions regarding in-patient care for suicidal patients. Issues and Innovations in Nursing Practice, 29 (5), 1042-1051	Acute	Northern Ireland
Modestin, J., & Kamm, A. (1990) Parasuicide in psychiatric inpatients: results of a controlled investigation. Acta Psychiatr Scand, 81, 225-230	Acute	Switzerland
Myers, K, M & Dunner, D.L. (1984) Self and other directed violence on a closed acute-care ward. Psychiatric Quarterly, 56(3), 178-188	Acute	USA
Neuner, T., Hubner-liebermann, B., Hausner, H., Hajak, G., Wolfersdorf, M & Hermann, Spiebl (2011). Revisiting the association of aggression and suicidal behaviour in schizophrenic inpatients. Suicide and life-threatening behaviour, 41 (2), 171-179	Acute	Germany
Neuner, T., Schmid, R., Wolfersdorf, M., & SpieBl, H. (2009) Predicting inpatient suicides and suicide attempts by using clinical and routine data? General Hospital Psychiatry, 30, 324-330	Acute	Germany
Nijman, H., Bowers, L., Oud, N & Jansen, G. Psychiatric nurses experiences within patient aggression (2005) Aggressive Behaviour, 31(3), 217-227.	Mixed	UK
Nijman,H., & Campo,J.M.L.G. (2002). Situational Determinants of Inpatient Self-Harm. Suicide and Life-Threatening Behaviour 32(2), 167-175	Mixed	Netherlands
O'Donovan, A (2007). Pragmatism rules: the intervention and prevention strategies used by pshychiatric nurses working with non-suicidal self-harming individuals, Journal off Psychiatric and Mental Health Nursing, 14, 64-71	Acute	Ireland
O'Shea, Picchioni, M.M., Mason, F.L., Sugarman, P.A & Dickens, G.L (2014) Predictive validity of the HCR-20 for inpatient self-harm. Comprehensive psychiatry, 55(8), 1937-1949.	Mixed	UK
Oulis, P., Lykouras, E., Dascalopoulou, E., & Psarros, C. (1996). Aggression among Psychiatric Inpatients in Greece. Psychopathology, 29, 174-180	Acute	Greece
Owen, C., Tarantello, C., Jones, M & Tennant, C. (1998) Repetitively violent patients in psychiatric units. Psychiatric services, 49(11), 1458-1461	Acute	Australia
Owen, C., Tarantello, C., Jones, M & Tennant, C. (1998) Violence and aggression in psychiatric units. Psychiatric services, 49(11), 1452-1457	Acute	Australia
Pao, P. (1969) The syndrome of delicate self-cutting. British Journal of Medical Psychology, 42(195), 195-206	Acute	UK
Parkes, J. The nature and management of aggressive incidents in a medium secure unit. (2003). Medicine, science and the law, 43(1), 69-74	Forensic	USA
Phillips,R.H., & Alkan,M. (1961). Some aspects of self-mutilation in the general population of a large psychiatric hospital, Psychiatric Quarterly, 35, 421-422	Acute	USA
Pirkis, J., Burgess, P & Jolley, D. (1999) Suicide attempts by psychiatric patients in acute inpatient, long-stay inpatient and community care. Social Psychiatry and Psychiatric Epidemiology, 34, 634-644.	Acute	Australia

Rinzler, C & Shapiro, D.A. (1968) Wrist-cutting and suicide. Journal of the Mount Sinai Hospital. 35, 485-488.	Acute	USA
Roaldset, J, O., & Bjorkly, S. (2010) Patients' own statements of their future risk for violent and self-harm behaviour: A propspective inpatient and post-discharge follow-up study in an acute psychiatric unit. Psychiatry Research, 178, 153-159	Acute	Norway
Rogers, P., Watt, A., Gray, N.s., MacCullouch, M & Gournay, K. (2002) Content of command hallucinations predicts self-harm but not violence in a medium secure unit. The Journal of Forensic Psychiatry. 13(2), 251-262.	Forensic	UK
Rosenthal,R.J.,Rinzler,C., Walsh,R., & Klausner,E. (1972). Wrist-Cutting Syndrome: The Meaning of a Gesture, American Journal of Psychiatry, 128(11), 1363-1368.	Acute	USA
Rush, B & Koel, C.J. (2008) Prevalence and profile of people with co-occurring mental and substance use disorders within a comprehensive mental health system. The Canadian Journal of Psychiatry, 53(12), 810-821	Acute	Canada
Sandy PT, & Shaw, DG (2012) Attitudes of Mental Health Nurses to Self-Harm in Secure Forensic Settings: A Multi-Method Phenomenological Investigation. Journal of Medicine and Medical Science Research, 1(4), 63-75.	Forensic	UK
Sansone, R.A & Sansone, L.A (2013) Preventing Wounds from Healing: Clinical Prevalence and Relationship to Borderline Personality. Innovations in Clinical Neuroscience, 10, 23-27.	Acute	Denmark
Shearer, S.L., Peters, C, P., Quaytman, M.S, & Wadman, B.E. (1988) Intent and lethality of suicide attempters among female borderline inpatients. Am J Psychiatry 145(11), 1424-1427	Acute	UK
Smith SE.(2002) Perceptions of service provision for clients who self-injure in the absence of expressed suicidal intent.Journal of psychiatric and mental health nursing, 9(5), 595-601.	Forensic	UK
SpieBL, H., Hubner-Liebermann, B & Cording, C. (2002) Suicidal behaviour of psychiatric in-patients. Acta psychiatri scand, 106, 134-138.	Acute	Germany
Steinert, T., Wiebe, C & Gebhardt, R.P. (1999) Aggressive behaviour against self and others among first-admission patients with schizophrenia. Psychiatric Services. 50(1), 85-90	Acute	Australia
Stewart, D., Bowers, L & Ross, J (2011) Managing risk and conflict behaviours in acute psychiatry: the dual role of constant special observation. Journal of Advanced Nursing, 68(6),1340-8.	Acute	UK
Stewart, D., Bowers, L & Warburton, F. (2009) Constant special observation and self harm on acute psychiatric wards: a longitudinal analysis. General Hospital Psychiatry, 31, 523-530.	Mixed	UK
Stewart, D., Bowers, L, Ross, J & James,K. (2011) Patient characteristics and behaviours associated with self-harm and attempted suicide on acute psychiatric wards.Journal of Clinical Nursing, 21, 1004-1013.	Acute	UK
Sweeny, S., & Zamecnik, K. (1981). Predictors of self-mutilation in patients with schizophrenia, American Journal of Psychiatry, 138(8), 1086-1089	Acute	USA
Swinton, M & Hopkins, R. Violence and self injury. Journal of Forensic Psychiatry, 7(3), 562-567	Forensic	UK
Swinton, M., Hopkins, R., & Swinton, J (1998) Reports of self-injury in a maximum security hospital. Criminal Behaviour and Mental Health, 8, 7-16.	Forensic	UK

Talseth, A.G., Lindseth, A., & Jacobsson, L. (1999) The meaning of suicidal psychiatric in patients experiences of being cared for by mental health nurses. Journal of Advanced Nursing, 29(5), 1034-1041	Acute	Norway
Tobin, M.B., Lim, L & Falkowski, W. (1991) How do we manage violent behaviour? British Journal of Clinical and Social Psychiatry, 8(1), 19-23	Acute	UK
Weber, M.T. (2002) Triggers for self abuse: A qualitative study. Acrhives of Psychiatric Nursing, 16 (3), 118-124	Acute	USA
Wheatley, M & Austin-Payne, H. (2009) Nursing staff knowledge and attitudes towards deliberate self-hram in adults and adolescents in an inpatient setting. Behavioural and Cognitive Psychotherapy. 37, 293-309	Acute	UK
White, J., Leggett, J & Beech, A. (1999) The incidence of self-harming behaviour in the male population of a medium-secure psychiatric hospital. The Journal of Forensic Psychiatry, 10(1), 59-68	Forensic	UK
Whittingtonn, R., Letiner, M., Barr, W., Lancaster, G & McGuire, J (2012) .Longitudinal Trends in Using Physical Interventions to Manage Aggression and Self-Harm in Mental Health Services. Psychiatric Services, 63 (5), 488-492.	Mixed	UK
Wilstrand,C., Lindgren,B.M., Gilje,F., & Olofsson,B. (2007). Being burdened and balancing boundaries: a qualitative study of nurses' experiences caring for patients who self-harm, Journal of Psychiatric and Mental Health Nursing, 14, 72-78.	Acute	Sweden
Wynn, R., Kvalvik, W., R., & Hynnkleiv, T. (2011) Attitudes to coercion at two Norwehian psychiatric units. Nordic Jounal of Psychiatry, 65 (2), 133-137	Acute	Norway
Yesavage,J.A. (1983). Relationships between measures of direct and indirect hostility and self-destructive behaviour by hospitalized schizophrenics, British Journal of Psychiatry, 143, 173-176.	PICU	UK

APPENDIX B: Measures

Self-Harm Questionnaire

Please indicate to what extent you agree with each statement below, by putting a cross in the appropriate box. Please consider each item in relation to individuals who deliberately or consciously engage in harming themselves by a variety of means, e.g. burning, cutting, self-poisoning, but who are not considered to be making a direct attempt to kill themselves: an act with a non-fatal outcome. All responses will be completely confidential.

	Strongly agree	Agree	Some what agree	Un-decided	Some what disagree	Disagree	Strongly disagree
People who self-harm are usually trying to get sympathy from others	☐	☐	☐	☐	☐	☐	☐
People should be allowed to self-harm in a safe environment	☐	☐	☐	☐	☐	☐	☐
A rational person can self harm	☐	☐	☐	☐	☐	☐	☐
Self-harming clients do not respond to care	☐	☐	☐	☐	☐	☐	☐
When individuals self-harm, it is often to manipulate carers	☐	☐	☐	☐	☐	☐	☐
People who self-harm are typically trying to get even with someone	☐	☐	☐	☐	☐	☐	☐
A self-harming client is a complete waste of time	☐	☐	☐	☐	☐	☐	☐
An individual has the right to self-harm	☐	☐	☐	☐	☐	☐	☐
Self-harm is a serious moral wrongdoing	☐	☐	☐	☐	☐	☐	☐
There is no way of reducing self-harm behaviours	☐	☐	☐	☐	☐	☐	☐
People who self-harm lack solid religious convictions	☐	☐	☐	☐	☐	☐	☐
Self-harm may be a form of reassurance for the individual that they are really alive and human	☐	☐	☐	☐	☐	☐	☐
Self-harming individuals can learn new ways of coping	☐	☐	☐	☐	☐	☐	☐
Acts of self-harm are a form of communication to their situation	☐	☐	☐	☐	☐	☐	☐
A self-harming client is a person who is only trying to get attention	☐	☐	☐	☐	☐	☐	☐
Self-harming clients have only themselves to blame for their situation	☐	☐	☐	☐	☐	☐	☐
For some individuals self-harm can be a way of relieving tension	☐	☐	☐	☐	☐	☐	☐
Self-harming clients have a great need for acceptance and understanding	☐	☐	☐	☐	☐	☐	☐
A self-harming client deserves the highest standards of care on every occasion	☐	☐	☐	☐	☐	☐	☐
I listen fully to self-harming clients' problems and experiences	☐	☐	☐	☐	☐	☐	☐
I feel concern for the self-harming client	☐	☐	☐	☐	☐	☐	☐
I feel critical towards self-harming clients	☐	☐	☐	☐	☐	☐	☐
I demonstrate warmth and understanding to self-harming clients in my care	☐	☐	☐	☐	☐	☐	☐
I help self-harming clients feel positive about themselves	☐	☐	☐	☐	☐	☐	☐
I feel to blame when my clients self-harm	☐	☐	☐	☐	☐	☐	☐
I acknowledge self-harming clients' qualities	☐	☐	☐	☐	☐	☐	☐
I find it rewarding to care for self-harming clients	☐	☐	☐	☐	☐	☐	☐
I can really help self-harming clients	☐	☐	☐	☐	☐	☐	☐
I would feel ashamed if a member of my family engaged in self-harm	☐	☐	☐	☐	☐	☐	☐
I am highly supportive to clients who self-harm	☐	☐	☐	☐	☐	☐	☐

Attitudes to Patients on the Ward

Please take a moment to reflect on your experience of working with patients on this ward. For the Purposes of this questionnaire we would like you to think about your feelings towards patients on this ward overall. We realise that you may have different mixtures of feelings about different patients on the ward now or that you have come across in the past. For this questionnaire we would like you to try and average those out and tell us what your responses are in general towards patients on this ward as a whole.

For each response listed below please indicate the frequency of your feelings towards patients on this ward. Please tick your choice quickly, rather than spending a long time considering it. We want to know your honest, gut feelings.

	Never	Seldom	Occasionally	Often	Very Often	Always
I like the patients	☐	☐	☐	☐	☐	☐
I feel frustrated with the patients	☐	☐	☐	☐	☐	☐
I feel drained by the patients	☐	☐	☐	☐	☐	☐
I respect the patients	☐	☐	☐	☐	☐	☐
I feel fondness and affection for the patients	☐	☐	☐	☐	☐	☐
I feel vulnerable in the patients' company	☐	☐	☐	☐	☐	☐
I have a feeling of closeness with the patients	☐	☐	☐	☐	☐	☐
I feel manipulated or used by the patients	☐	☐	☐	☐	☐	☐
I feel uncomfortable or uneasy with the patients	☐	☐	☐	☐	☐	☐
I feel I am wasting my time with the patients	☐	☐	☐	☐	☐	☐
I am excited to work with the patients	☐	☐	☐	☐	☐	☐
I feel pessimistic about the patients	☐	☐	☐	☐	☐	☐
I feel resigned about the patients	☐	☐	☐	☐	☐	☐
I admire the patients	☐	☐	☐	☐	☐	☐
I feel helpless in relation to the patients	☐	☐	☐	☐	☐	☐
I feel frightened of the patients	☐	☐	☐	☐	☐	☐
I feel angry towards the patients	☐	☐	☐	☐	☐	☐
I enjoy spending time with the patients	☐	☐	☐	☐	☐	☐

	Never	Seldom	Occasionally	Often	Very Often	Always
Interacting with the patients makes me shudder	☐	☐	☐	☐	☐	☐
The patients make me feel irritated	☐	☐	☐	☐	☐	☐
I feel warm and caring towards the patients	☐	☐	☐	☐	☐	☐
I feel protective towards the patients	☐	☐	☐	☐	☐	☐
I feel oppressed or dominated by the patients	☐	☐	☐	☐	☐	☐
I feel that the patients are alien, other, strange	☐	☐	☐	☐	☐	☐
I feel understanding towards the patients	☐	☐	☐	☐	☐	☐
I feel powerless in the presence of the patients	☐	☐	☐	☐	☐	☐
I am happy and content in the patients' company	☐	☐	☐	☐	☐	☐
I feel outmanoeuvered by the patients	☐	☐	☐	☐	☐	☐
Caring for the patients makes me feel satisfied and fulfilled	☐	☐	☐	☐	☐	☐
I feel exploited by the patients	☐	☐	☐	☐	☐	☐
I feel patient when caring for the patients	☐	☐	☐	☐	☐	☐
I feel able to help the patients	☐	☐	☐	☐	☐	☐
I feel interested in the patients	☐	☐	☐	☐	☐	☐
I feel unable to gain control of the situation with the patients	☐	☐	☐	☐	☐	☐
I feel intolerant. I have difficulty tolerating the patients' behaviour	☐	☐	☐	☐	☐	☐

SF-36 Health Survey

Please answer every question. Some questions may look like others, but each one is different. Please take the time to read and answer each question carefully by checking the box that best represents your response.

Q1.1 **In general, would you say your health is:**

- *Excellent* ☐
- *Very good* ☐
- *Good* ☐
- *Fair* ☐
- *Poor* ☐

Q2.1 **Compared to one year ago, how would you rate your health in general now?**

- *Much better now than a year ago* ☐
- *Somewhat better now than a year ago* ☐
- *About the same as one year ago* ☐
- *Somewhat worse than one year ago* ☐
- *Much worse than one year ago* ☐

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

Q3.1 **Vigrorous activities, such as running, lifting heavy objects, participating in strenuous sports.**

- *Yes, limited a lot* ☐
- *Yes, limited a little* ☐
- *No, not limited at all* ☐

Q3.2 **Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf.**

- *Yes, limited a lot* ☐
- *Yes, limited a little* ☐
- *No, not limited at all* ☐

Q3.3 **Lifting or carryin groceries.**

- *Yes, limited a lot* ☐
- *Yes, limited a little* ☐
- *No, not limited at all* ☐

Q3.4 **Climbing several flights of stairs.**

- *Yes, limited a lot* ☐
- *Yes, limited a little* ☐
- *No, not limited at all* ☐

Q3.5 **Climbing one flight of stairs.**

- *Yes, limited a lot* ☐
- *Yes, limited a little* ☐
- *No, not limited at all* ☐

Q3.6 **Bending, kneeling or stooping.**

Yes, limited a lot ☐

Yes, limited a little ☐

No, not limited at all ☐

Q3.7 **Wlaking more than one mile.**

Yes, limited a lot ☐

Yes, limited a little ☐

No, not limited at all ☐

Q3.8 **Walking several blocks.**

Yes, limited a lot ☐

Yes, limited a little ☐

No, not limited at all ☐

Q3.9 **Walking one block.**

Yes, limited a lot ☐

Yes, limited a little ☐

No, not limited at all ☐

Q3.10 **Bathing or dressing yourself.**

Yes, limited a lot ☐

Yes, limited a little ☐

No, not limited at all ☐

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

Q4.1 **Cut down the amount of time you spent on work or other activities.**

Yes ☐ *No* ☐

Q4.2 **Accomplished less than you would like.**

Yes ☐ *No* ☐

Q4.3 **Were limited in the kind of work or other activities.**

Yes ☐ *No* ☐

Q4.4 **Had difficulty performing the work or other activities (for example, it took extra time).**

Yes ☐ *No* ☐

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

Q5.1 **Cut down the amount of time you spent on work or other activities.**

Yes ☐ *No* ☐

Q5.2 **Accomplished less than you would like.**

Yes ☐ *No* ☐

Q5.3 **Didn't do work or other activities as carefully as usual.**

Yes ☐ *No* ☐

Q6.1 **During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours or groups?**

Not at all ☐
Slightly ☐
Moderately ☐
Quite a bit ☐
Extremely ☐

Q7.1 **How much bodily pain have you had during the past 4 weeks?**

Not at all ☐
Slightly ☐
Moderately ☐
Quite a bit ☐
Extremely ☐

Q8.1 **During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?**

Not at all ☐
Slightly ☐
Moderately ☐
Quite a bit ☐
Extremely ☐

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks:

Q9.1 **did you feel full of pep?**

All of the time ☐
Most of the time ☐
A good bit of the time ☐
Some of the time ☐
A littel of the time ☐
None of the time ☐

Q9.2 **have you been a very nervous person?**

All of the time ☐
Most of the time ☐
A good bit of the time ☐
Some of the time ☐
A littel of the time ☐
None of the time ☐

Q9.3 **have you felt so down in the dumps nothing could cheer you up?**

All of the time ☐
Most of the time ☐
A good bit of the time ☐
Some of the time ☐
A littel of the time ☐
None of the time ☐

Q9.4 **have you felt calm and peaceful?**

All of the time ☐
Most of the time ☐
A good bit of the time ☐
Some of the time ☐
A littel of the time ☐
None of the time ☐

Q9.5 **did you have a lot of energy?**

All of the time ☐
Most of the time ☐
A good bit of the time ☐
Some of the time ☐
A littel of the time ☐
None of the time ☐

Q9.6 **have you felt downhearted and blue?**

All of the time ☐
Most of the time ☐
A good bit of the time ☐
Some of the time ☐
A littel of the time ☐
None of the time ☐

Q9.7 **did you feel work out?**

All of the time ☐
Most of the time ☐
A good bit of the time ☐
Some of the time ☐
A littel of the time ☐
None of the time ☐

Q9.8 **have you been a happy person?**

- *All of the time* ☐
- *Most of the time* ☐
- *A good bit of the time* ☐
- *Some of the time* ☐
- *A littel of the time* ☐
- *None of the time* ☐

Q9.9 **did you feel tired?**

- *All of the time* ☐
- *Most of the time* ☐
- *A good bit of the time* ☐
- *Some of the time* ☐
- *A littel of the time* ☐
- *None of the time* ☐

Q10.1 **During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social actvities (like visiting friends, relatives, etc.)?**

- *All of the time* ☐
- *Most of the time* ☐
- *Some of the time* ☐
- *A little of the time* ☐
- *None of the time* ☐

How TRUE or FALSE are the following statements for you?

Q11.1 **I seem to get sick a little easier than other people**

- *Definitely true* ☐
- *Mostly true* ☐
- *Don't know* ☐
- *Mostly false* ☐
- *Definitely false* ☐

Q11.2 **I am as healthy as anybody I know**

- *Definitely true* ☐
- *Mostly true* ☐
- *Don't know* ☐
- *Mostly false* ☐
- *Definitely false* ☐

Q11.3 **I expect my health to get worse**

- *Definitely true* ☐
- *Mostly true* ☐
- *Don't know* ☐
- *Mostly false* ☐
- *Definitely false* ☐

Q11.4 **My health is excellent**

Definitely true ☐
Mostly true ☐
Don't know ☐
Mostly false ☐
Definitely false ☐

Q12.1 **[Office use only] Time period**

Baseline ☐
Outcome ☐

Q12.2 **[Office use only] Ward Research number**

	0	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
First digit	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Second digit	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q12.3 **[Office use only] Respondent Research number**

	0	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
First digit	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Second digit	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Basic Staff Data

Q1.1 What is your age in years?

Under 20 ☐ 20 - 29 ☐ 30 - 39 ☐ 40 - 49 ☐
50 - 59 ☐ 60 or over ☐

Q1.2 What is your gender?

Male ☐ Female ☐

Q1.3 What is your ethnicity?

White ☐ Irish ☐ Caribbean ☐ African ☐
South Asian ☐ Other ☐

Q1.4 Are you...?

Single ☐ Divorced or Separated ☐ Widowed ☐ Married or Cohabiting ☐

Q1.5 Do you have dependent children living at home?

Yes, aged under 12 ☐ Yes, aged between 12 and 21 ☐ No ☐

Q1.6 How long have you been in your current post on this ward?

1 year or less ☐ Between 1 and 3 years ☐ Between 3 and 5 years ☐ More than 5 years ☐

Q1.7 How long have you been working in psychiatry? (inlcude training time if relevant)

1 year or less ☐ Between 1 and 3 years ☐ Between 3 and 5 years ☐ More than 5 years ☐

Q1.8 What is your discipline/occupation?

Nurse ☐ Social Worker ☐ Psychologiist ☐ Health Care Asst. ☐
Psychiatrist ☐ Occ. Therapist ☐ Other ☐

Q1.9 To what extent have you been confronted with mild physical violence (patients kicking, hitting, pushing, punching, scratching, pulling hair, biting, attacking you, etc..., however all with no real harm or injury as a result or only minor injuries as a result) during the last year in the course of your work?

Never ☐ Occasionally ☐ Sometimes ☐ Often ☐
Frequently ☐

Q1.10 To what extent have you been confronted with severe physical violence (patients attacking you with severe injuries as a result, for example broken bones, deep lacerations, internal injuries, loss of teeth, loss of consciousness, and therefore in need of medical treatment or hospitalisation) during the last year in the course of your work?

Never ☐ Occasionally ☐ Sometimes ☐ Often ☐
Frequently ☐

Q2.1 [Nurses/HCAs/assistants only] What is your AfC pay band?

2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐
7 ☐ 8 ☐

Q2.2 [Nurses only] Have you ever attended a prevention and management of violence and aggression (of any type including C&R) course of at least three days in duration?

Yes ☐ No ☐

Q3.1 [Office use only] Ward Research number

	0	1	2	3	4	5	6	7	8	9
W First digit	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
W Second digit	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Q3.2 [Office use only] Respondent Research number

	0	1	2	3	4	5	6	7	8	9
R First digit	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
R Second digit	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

APPENDIX C: Original factor structure of the SHAS

Table 1

Item factor loadings and mean (SD) respondent score

Item number		Competence Appraisal	Care Futility	Client Intent Manipulation	Acceptance and Understanding	Rights and Responsibilities	Needs Function	Item mean	Item SD
20	I listen fully to self-harming clients' problems and experiences[1]	0.75						2.39	1.02
23	I demonstrate warmth and understanding to self-harming clients in my care[1]	0.75						2.73	1.00
26	I acknowledge self-harming clients' qualities[1]	0.68						2.65	1.06
30	I am highly supportive to clients who self-harm[1]	0.66						3.35	1.16
21	I feel concern for the self-harming client[1]	0.56						2.13	0.86
28	I can really help self-harming clients[1]	0.52						3.71	1.04
24	I help self-harming clients feel positive about themselves[1]	0.44						2.96	1.15
10	There is no way of reducing self-harm behaviours		0.79					2.28	1.21
7	A self-harming client is a complete waste of time		0.75					1.69	1.01
4	Self-harming clients do not respond to care		0.60					2.63	1.27
9	Self-harm is a serious moral wrongdoing		0.57					2.35	1.25
16	Self-harming clients have only themselves to blame for their situation		0.54					2.16	1.03
1	People who self-harm are usually trying to get sympathy from others			0.69				3.40	1.52
6	People who self-harm are typically trying to get even with someone			0.68				2.58	1.09
5	When individuals self-harm, it is often to manipulate carers			0.63				3.52	1.41
15	A self-harming client is a person who is only trying to get attention			0.62				3.01	1.39
18	Self-harming clients have a great need for acceptance and understanding[1]				0.84			2.30	0.90
17	For some individuals self-harm can be a way of relieving tension[1]				0.72			2.41	0.99
11	People who self-harm lack solid religious convictions				0.45			2.33	1.20
2	People should be allowed to self-harm in a safe environment[1]					0.73		3.84	1.72
8	An individual has the right to self-harm[1]					0.51		3.18	1.47
12	Self-harm may be a form of reassurance for the individual that they are really alive and human[1]						0.71	3.19	1.36
14	Acts of self-harm are a form of communication to their situation[1]						0.64	2.42	0.91
13	Self-harming individuals can learn new ways of coping[1]							2.09	0.86
19	A self-harming client deserves the highest standards of care on every occasion[1]							2.28	1.22
22	I feel critical towards self-harming clients							3.01	1.34
25	I feel to blame when my clients self-harm							2.63	1.38
27	I find it rewarding to care for self-harming clients[1]							3.91	1.25
29	I would feel ashamed if a member of my family engaged in self-harm							2.97	1.40

APPENDIX D: Interview topic guide

1. Thinking about the last person you cared for who self harmed, why do you think they self harmed?

2. Have you ever worked with people who self harm for different reasons?

3. How do you feel about self harm, compared to some of the other behaviours you experience in your work (e.g. sadness, psychosis)

4. Have you always felt this way?

5. What kind of interventions do you use when supporting people who self harm? Is there anything else?

6. How do you decide which interventions to use? Do other people use the same interventions?

7. Some services have started to use ‘harm minimsation methods’. Have you heard of this approach? [If not, explain harm minimisation]. Do you use harm minimisation on your ward?

8. What do you think about the harm minimisation approach? Would it be possible within psychiatric inpatient services?

9. Do you distinguish between self harm, and attempted suicide? How?

APPENDIX E: 15-point checklist of criteria for good thematic analysis

Process	No.	Criteria
Transcription	1	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'.
Coding	2	Each data item has been given equal attention in the coding process.
	3	Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive.
	4	All relevant extracts for all each theme have been collated.
	5	Themes have been checked against each other and back to the original data set
	6	Themes are internally coherent, consistent, and distinctive.
Analysis	7	Data have been analysed -/ interpreted, made sense of -rather than just paraphrased or described.
	8	Analysis and data match each other -/ the extracts illustrate the analytic claims.
	9	Analysis tells a convincing and well-organized story about the data and topic.
	10	A good balance between analytic narrative and illustrative extracts is provided
Overall	11	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.
Written report	12	The assumptions about, and specific approach to, thematic analysis are clearly explicated.
	13	There is a good fit between what you claim you do, and what you show you have done -/ ie, described method and reported analysis are consistent.
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis.
	15	The researcher is positioned as active in the research process; themes do not just 'emerge'.

APPENDIX F: Reflexive statement

This reflexive statement is an honest examination of how my personal values and experiences may have shaped the collection and analysis of interview data. It is also an evaluation of the efforts I made to maintain objectivity in order to ensure the analysis was not unduly influenced by my own preconceptions and a true reflection of participant's accounts.

I am not a clinician, but did spend some time working as a Healthcare Assistant (HCA) on an acute adolescent ward in my early 20s. This means I have worked as part of an inpatient nursing team, and have supported people who self harm in an inpatient environment, and so have personal experience directly relevant to this study.

My main concern in relation to the interview study was that my knowledge of the antipathy scores of participants (e.g. that they demonstrated positive/negative attitudes) might influence how I conducted the interview, and interpreted the data. I therefore made a conscious effort to question all participants in the same manner, regardless of their antipathy scores. I also believe my personal experience as a HCA helped me to approach the interview data in a non-judgemental way because I was able to appreciate some of the challenges encountered by nursing teams supporting people who self harm.

Before I began interviewing participants, and after completing the systematic review of the literature, I felt very strongly that views of service users who self harm as 'attention seeking' and 'manipulative' were wrong, and illustrative of poor practice and negative attitudes towards people who self harm. I was also in favour of the use of the term 'non-suicidal self injury', as I had come across accounts from service users who were frustrated that staff assumed they were suicidal when they self harmed. I was very aware of my personal views, which I discussed with my supervisors. After listening to the experiences of staff, my views regarding these issues changed, and I believe this is because I was able to put my own beliefs aside, and keep an open mind during data collection.

Finally, my education was in the biological sciences, and I believe this positivist training meant I was very conscious of not over interpreting, or deviating from, what was expressed during the interviews. I feel this helped me maintain my objectivity, and ensure that the analysis was an accurate representation of participant's accounts.